WHAT IS THE LIVED EXPERIENCE OF ADVANCED NURSE PRACTITIONERS OF MANAGING RISK AND PATIENT SAFETY IN ACUTE SETTINGS? A PHENOMENOLOGICAL PERSPECTIVE

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A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Doctor of Philosophy

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June 2019

Word Count: 86, 044

Abstract

Background: Managing clinical risk and patient safety is high on clinical and political agendas. Advanced Nurse Practitioners (ANPs) are frontline practitioners making critical decisions regarding risk and patient safety. Whilst research around nurse decision-making has been conducted, the extent to which ANPs manage and navigate patient safety and risk is under-researched.

Research question: What is the lived experience of Advanced Nurse Practitioners of managing risk and patient safety in acute settings? A phenomenological perspective.

Method: Ten ANPs across three acute settings were recruited and iterative data collected over ten months on experiences of managing risk and safety (reflective interviews, written reflections, researcher journal). Methods were underpinned by Heidegger's Interpretive Phenomenology. Data analysis based on Van Manen's approach was assisted by NVivo 11 to facilitate circles of interpretation with each data source.

Findings: In an environment driven by time pressures, how practitioners cope with managing risk and patient safety is dependent on the presenting situation, breadth of knowledge-base, application of evidence, degree of perceived management support, and channelling of emotive moods. In situations of uncertainty, insufficient knowledge, and/or lack of information, practitioners were guided by care, concern, worry, feeling happy or comfortable and, in critical times, fuelled by fear. These were illuminated to be both drivers and barriers to practitioners' capabilities in grasping patient presentations. Snapshot judgements were individualized and negotiated dependent on practitioners' and patients' capacity to cope with risk. Experiences of risk often identified a learning need or knowledge deficit, revealing an opportunity to develop and advance ANP practice.

Implications: These findings have implications for the preparation, training, and on-going educational and emotional support of ANPs within their practice. Recognising the emotional toll of managing risk and providing the necessary support will ultimately positively impact recruitment and retention of these crucial healthcare professionals.

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[1] References to specific terminology from the main philosophical text *Being and Time,* Heidegger (1962). are italicized throughout the thesis for clarity of understanding e.g. *Being* and *temporality.* Heidegger (1962) quotation page numbers are shown e.g. p.86/50. The first number is the page number of the translated text, the second number refers to the original German edition.

Acknowledgements

Thank you to my supervision team John Albarran, Rachel Sales and Rebecca Hoskins for their support, guidance and *Being-with* me throughout my PhD journey.

Thank you to one of my oldest friends, Caroline Fell Kurban, for her tireless proofreading, positivity and generosity of her time that I will never be able to repay.

A special thank you to my sister-in-law Andrea Britchford for her time and *attention to detail* and a big thank you to all my friends and family for being there for me in so many ways.

All my love and eternal gratitude go to my husband, Andrew Girdher, and the best three children in the world, Amelie, Priya, and Mani who have been so incredibly understanding and supportive of "Mummy doing her work again".

Finally, I am hugely grateful to the ten Advanced Nurse Practitioners who generously offered their *Being* and very precious *Time* for this research. I thank them for their openness, insights, rich emotive descriptions and earnest determination to find the words to illuminate such a critical area of practice. These practitioners, both individually and collectively, provided a voice worthy to be heard.

Chapter One – Introduction

1.1 Introduction

This chapter provides a background, context and framework for this study which aims to explore "What is the lived experience of Advanced Nurse Practitioners of managing risk and patient safety in acute settings?"

1.2 Background to the Study

Risk is high on clinical and political agendas. This current focus on risk within healthcare is imperative as the consequences of poor management and subsequent compromise of patient safety can have critical and sometimes devastating consequences for patients (Burton and Wells, 2016). Well publicised clinical mistakes and high-profile incidents have led to calls for stricter controls and monitoring of clinicians through protocols and evidence-based guidelines to ensure that care is standardised, effective, good quality and safe (Goodwin, 2018). Patients are increasingly better informed, empowered by access to information and support from social media (Househ, Borycki and Kushniruk, 2014). This heightened focus on patient safety has led to a loss of public trust and faith in healthcare provision (Hutchison, 2016) and increased awareness of the fallibility of clinicians (Ilangaratne, 2004).

Advanced Nurse Practitioners (ANPs) are registered nurses who have additional training, qualified often to Masters level and are able to see, treat, diagnose and discharge patients autonomously (RCN, 2018).

Clinical risk is traditionally managed through standardisations of the implementation of evidence-based guidelines, driven by policies such as the NHS Outcome Framework which holds NHS England accountable for improvements in health outcomes (DH, 2018; Valderas, Fitzpatrick and Roland, 2012). Policy makers view guidelines as a tool to close the gap between what clinicians do and what scientific evidence supports to achieve consistent, efficient and safe patient care (Woolf *et al.*, 1999).

1.2.1 The Researcher's Background

I am an ANP with a background of working in Emergency Departments (ED), Walk in Centres and, currently, an Urgent Care Centre (UCC). Along with my colleagues, I manage risk and patient safety at varying levels on a daily basis. Clinical guidelines, protocols and decision-making tools are fundamental to my daily role in supporting and guiding safe practice and cost-effective quality care. However, in the course of my work, I have observed myself and others making decisions around risk and safety through using a multitude of approaches alongside this guidance, particularly when faced with atypical presentations, complexity and uncertainty. Naylor *et al.* (2016) refers to an implementation gap between the theory of policy-driven strategies that are put in place to enhance patient safety and the reality of practice. This thesis aims to address this gap moving beyond the existing theoretical positivist paradigm, through a more expansive conception of theory and research in the field, by shedding light on the ANP perspective of this phenomenon. The addition to the literature provided by this research, is humanistic, bottom-up evidence that can be used to inform existing policies and practice in acute settings.

1.2.2 The Evolving Role of Advanced Nurse Practitioners

The development of the ANP role arose not only out of a drive within the nursing profession to advance but also from a workforce development plan to address a lack of doctors with the increased clinical complexity and needs of an ageing population (Reynolds and Mortimore, 2018). ANPs make critical decisions regarding the risk and safety of their patients (HEE, 2016). These practitioners commonly work in acute settings such as ED's, UCC's, and Minor Injury Units (MIU). In these healthcare settings, decisions are required to be made in a timely manner, often with limited information and conflicting facts (Lyneham, Parkinson and Denholm, 2008). The current context of increased clinical complexity and the necessity to make quick decisions about the risk and safety patients is increasingly evidenced (Pirret, Neville and La Grow, 2015; Rasmussen, 2012; Bowen, 2008; Ritter, 2003; Burman *et al.*, 2002; Offredy, 1998).

The ANP role has expanded in the face of a heightened awareness of clinical risk, empowered patients and a growing lack of trust in healthcare professionals. Compounded by the shortage of doctors, this has led to the development of ANPs working across role boundaries that were traditionally those of their medical colleagues. These factors have also led to a shift of ANPs from prescribed roles of carrying out delegated tasks, towards independent, autonomous practitioners whose decision-making in terms of assessing, treating and discharging patients has been core to their contribution to achieving the aims of the NHS (Albarran, 2006). A fuller review of the evolution of the ANP role can be found in Chapter Two.

1.2.3 The Role of Evidence-Based Guidelines and Policies

Risk and maintaining patient safety has become critical to healthcare providers, the public and economics. This focus legitimizes the enquiry into this area of practice. Health scandals such as Alder Hey, Bristol Children's, Kent and Canterbury, Gosport and Mid Staffordshire have led to national and global concerns about patient safety, placing risks within the healthcare system high on the public agenda (Burton and Wells, 2016; Alghrani *et al.*, 2011). These factors have led to much policy discussion towards developing evidence-based practice in health provision (Bolt and Huisman, 2015).

Evidence-based clinical guidelines are derived and driven by policies that aim to support decision-making, standardize care and ultimately improve the safe provision of healthcare (Carayon, 2016). The National Institute of Clinical Excellence (NICE) guidance and clinical decision rules (CDR) derived from large studies are good examples of this. Clinical decision guidelines are research-based decision-making tools incorporating variables from the history, physical examination or simple tests (Stiell, 2000). Evidence-based medicine (EBM) aims to improve efficiency, standardise care, reduce medical uncertainty and is vital to all practitioners, particularly for those with less knowledge and experience (Benner, 1984). Furthermore EBM protects both patients and ANPs, especially in the wake of global health scandals (Seale, Cavers and Dixon-Woods, 2006).

Arguably, protocols, guidance and decision making tools have arisen from the positivist tradition of objectivity that has dominated the field of medical research enabling decisions to be quantifiable and evidence-based (Welsh and Lyons, 2001).

Despite the unquestionable fundamental imperative of EBM, it must be considered that positivism assumes no difference between social and natural phenomena. However, within the humanities, it is believed that there is a great difference between social and natural phenomena. Polkinghorne (1983), for example, believes that the most significant difference between the two approaches is that in the humanities, humans are seen as having agency – the ability to make choices based on their own free will. Furthermore, Oakeshott (1975) describes the natural world as having processes, and the human world as having practices. In other words, nature takes its course, but humans learn and develop theirs. The positivist approach has limitations when dealing with humans as it disregards emotions and behaviours (Lawson and Floyd, 1996; Weed, 1995). Positivism has also been criticised as being "part and parcel of an instrumental, utilitarian trend in the modern world, which… lies at the heart of the growing sense of alienation, moral malaise and social disintegration" (Buchanan, 1998). Indeed, "it is a frame of mind that views the world as if ends and means were independent and hence fosters an outlook primed for treating human beings as a means to achieve goals not of their own choosing" (Buchanan, Reddy and Hossain, 1994). Buchanan (1998) defines positivism as making predictions to "hypothesize in advance about the strength and direction of relationships among independent variables or about the results of experimental interventions" and providing explanations "to give or show the cause of a phenomenon". The well-known benefits of this are to provide trustworthy, objective, scientific knowledge. Indeed, this forms the basis of evidence-based standards imperative for reducing risk, efficiency, effectiveness and public

reassurances in today's healthcare (Fulford, Peile and Carroll, 2014). Conversely, the humanistic approach is described as:

> sense-making – to put forward an interpretation of events to stimulate a discerning awareness and appreciation of their significance; sensitization – to stimulate a more receptive, more responsive and more delicate awareness of the nuances of a given situation through analytic descriptions; and critique – to evaluate and analyse the merits and demerits of extend and potential states of affairs. (Buchanan, 1998, p.445).

The reality of practice for ANP's and other practitioners in healthcare is in a grey area between the idealistic positivism model dominating healthcare and a humanistic understanding of the less quantifiable risk factors within the complexity of patients and clinical situations. This is especially true with regard to rapidly advancing roles such as ANPs. Thus, a shift in focus towards qualitative humanistic research of experiences of risk may be beneficial to the advancement of understanding in this area because if risk and patient safety are to be effectively managed then it needs to be understood on all levels including a humanistic perspective of the ANPs themselves.

1.2.4 A Call for the Inclusion of Humanistic Evidence

There may be criticism that due to the non-tangible nature of the humanistic experience of managing risk and patient safety, it cannot be easily studied or replicated, and therefore does not provide solid evidence of the efficacy of this approach. However this approach seeks to recognise and shed light on complex clinical judgements that today's clinicians are required to make, regarding risk, that may ultimately inform core ANP education and training (Pirret, Neville and La

Grow, 2015; Rasmussen, 2012; Ritter, 2003; Burman *et al.*, 2002; Offredy, 1998). Thus, the inclusion of more humanistic evidence on how risk is managed will have benefits for policy, education and support. Furthermore, to understand the processes involved will illuminate the reality of practice and ultimately enhance patient safety. Therefore, the current priority of risk and patient safety justifies direct investigation of ANPs experiences through a humanistic, phenomenological approach.

1.3 Development of the Research Question

In developing the focus of enquiry and framework for this study, a comprehensive literature review identified the nature and scope of what is known about ANPs experiences with regard to risk and safety and highlighted the gaps in knowledge and understanding. It emerged that there is a body of literature regarding the efficiency and use of guidelines and the way in which nurses and ANPs make decisions with regard to the linear and non-linear interface and in the context of uncertainty and complexity. However, very little direct evidence exists on the management of risk and patient safety in experienced by ANPs in acute settings.

The perspective of ANPs in their experience on managing risk and patient safety will further enrich existing knowledge on how the role is advancing in acute settings. In the wake of scandals and low public confidence in healthcare, shedding light on these experiences of ANPs is imperative to achieve a better understanding and ultimately to enhance patient safety. Indeed, identifying what happens in practice from a phenomenological perspective may offer unique insights about the lived experience of managing risk and patient safety within this context.

1.4 Purpose and the Philosophical Approach of the Study

The purpose of this study is to provide an in-depth understanding of how ANPs experience risk and navigate patient safety by asking

> "What is the lived experience of Advanced Nurse Practitioners of managing risk and patient safety in acute settings?"

This investigation sits within a context of a critical focus on patient safety reflected in changing role boundaries, policy changes and patient mistrust. It is particularly pertinent with healthcare scandals and current national policies such as the NHS Outcomes Framework which is seeking to measure success in achieving treatment in safe environments and protecting patients from avoidable harm (Black, 2014).

Findings derived from lived experiences of how risk and safety is experienced from the perspectives of today's ANPs adds to the body of literature within healthcare that is draws on humanistic research. This study illuminates and seeks to better understand the gap between policy and practice of how risk and patient safety is experienced. In the context of staffing, economic and political pressures, these findings will inform ANPs, managers, educators and healthcare policy makers to aid with the safe advancement of the ANP role and ultimately enhance patient safety.

The philosophical approach evident in this thesis is Heidegger's Interpretive Phenomenology. This is clear from the position of the researcher as well as the

research design. The targeted sampling, interpretive data collection, cyclical analysis and philosophical interpretation of the findings demonstrate this. A specific example as fundamental evidence of this approach is in the iterative study design which allowed for repeated interpretations and reinterpretations of multiple data sets over a period of time. This aligns with the world view that knowledge is an interpretation and is temporal according to moments in time.

This study is not a critique of positivism but rather aims to address the balance of the historical healthcare leanings towards the positivist paradigm. This offers an alternative lens within which to seek an understanding of a concept that is little understood. Furthermore, interpretivism affords a deeper and wider perspective which recognises that understanding is achieved from a place of interpretation and reinterpretation according to perspective and time. Researching the experience and management of risk and patient safety within today's healthcare settings has a clear application to social constructionism. Indeed, the theory of knowledge according to which human development is socially situated could offer a critical understanding of how ANPs face the challenges within this area of their practice. Whilst social constructivism and interpretivism are related approaches which share the goal of seeking to "understand the complex world of lived experience" (Schwandt, 1994), the interpretive perspective moves further away from the positivist paradigm and identifies that "knowledge consists of those constructions about which relative consensus exists….multiple knowledge's can co-exist" (Guba and Lincoln, 1994). Parsons (2010) places interpretivism as a subset of constructivism which argues that all human action passes through the filters of individual interpretation and thus there can be no pretence in entering what

positivists may refer to as the real world. Whilst this research is aligned to the belief that a *real world* can never truly evade the *filter of interpretation,* it is contestable whether interpretivism is a *subset* of social constructivism. Arguably, these two approaches are inextricably linked, each with their own value that have the potential to work alongside each other synergistically. Indeed, the philosophical approach of Interpretive phenomenology used in this research did not rank, segregate or oppose alternative approaches but rather recognised, utilised and encompassed elements from other disciplines when deemed appropriate.

It is important to acknowledge and justify the choice of incorporating, at times, a seemingly pragmatic approach. Indeed, whilst using Heidegger's Interpretive Phenomenology, positivist strategies were employed such as the CASP critical appraisal, utilising terms such as bias, generalisability and sampling. It is imperative to recognise that whilst the Interpretivism was selected as an appropriate lens through which to investigate this subject area, this is not a rejection of quantitative approaches. On the contrary, it is my belief that qualitative and quantitative methods do not need to sit at opposite ends of a spectrum, rather can be interwoven to work together positively. Moreover, if done effectively, this can achieve a new era of research unencumbered by old debates (Johnson and Turner, 2003). Consequently, this research concurs with the view that interpretivists do not necessarily reject the positivist account of knowledge. Furthermore, the combination can compensate for mutual weaknesses (Tashakkori and Teddlie, 2003).

1.5 Organization of the Thesis

Having outlined the background and purpose of the study, expected outcomes, and target audience in Chapter One, Chapter Two defines the terms of ANP risk and patient safety followed by an examination of the literature strategy and analysis of selected literature. The key themes that emerged for the literature are presented, synthesized and analysed. Chapter Three discusses the underpinning approach of German philosopher Martin Heidegger's Interpretive Phenomenology (IP). Chapter Four presents the methods including purposeful sampling, data collection of semi-structured interviews and written reflections and Van Manen (1997) thematic data analysis. Chapter Five presents the findings, interpreting themes of each participant's lifeworld, followed by an interpretation of the collective worldhood of the phenomenon. Chapter Six presents a discussion of the findings in terms of redefining risk, re-conceptualising care. Finally, in Chapter Seven conclusions are drawn, limitations outlined, final reflexivity analysed, and implications and recommendations presented. Reflexivity boxes punctuate this thesis with reflective thoughts and insights through the journey of this research.

Chapter Two – Literature Review

2.1 Introduction

This chapter investigates what is known about how ANPs manage risk and patient safety in acute settings. The review is set against the backdrop of the growth of advanced nursing roles and developments in health policy, health economics, and EU working directives, all of which have seen the expansion of non-medical roles within healthcare (Reynolds and Mortimore, 2018). Within this new paradigm, traditional nursing roles have advanced to independent, autonomous practitioners (RCN, 2018). Indeed, the continual re-evaluation and re-definition of the roles of ANPs is crucial in keeping up with the rapidly changing and broadening remit that today's ANPs face (Duffield *et al.*, 2009; Gardner, Chang and Duffield, 2007). The research question guiding this chapter is:

"What is the lived experience of Advanced Nurse Practitioners of managing risk and patient safety in acute settings?".

A comprehensive literature review was undertaken to determine the nature and scope of what is known and to identify gaps in existing understanding to inform and guide further research.

2.2 Advanced Nurse Practitioners (ANP)

The ANP role was identified by the UK National Workforce Development Programme (NWDP) as being critical to enhancing the capacity and capability for

service improvement, addressing the future demographic, shortages of medical staff, and professionally advancing the nursing profession (NWDP, 2005). The Health Service Fit for the Future report involved planning and preparation of future workforce according to predicted demand (NWDP, 2005). This included service redesign and commissioning of new roles such as ANPs for improvement regarding efficiency, retention, productivity through development of existing staff (Scottish Government, 2005). Subsequently, according to the International Council of Nurses (ICN) the ANP role is a well-established both nationally and Internationally (ICN, 2018).

The National Health Service England (NHSE) defines an ANP as:

> an experienced and highly educated Registered Nurse who manages the complete care for the person in their care. Advanced practice is a level of practice, rather than a type or specialty of practice. It has four pillars of practice as part of the core role and function: clinical practice; leadership; facilitation of learning; evidence research and development (NHSE, 2016).

While standardisation of advanced practice roles continues to evolve, responsibility for competence in practice at any level remains rooted within the NMC code (NMC, 2016). Thus, ANPs are recognised as being accountable for their actions and omissions, including their decisions in line with NMC guidelines, and "must be embedded into nursing governance structures, with clear lines of responsibility and accountability leading through the professional nursing line to the Executive Nurse Director" (NMC, 2016).

This role is characterised by autonomous decision-making that includes assessment, diagnosis, and treatment including prescribing, for people with complex, multi-dimensional needs (NMC, 2016):

> Decisions are made using high-level expert knowledge and skills with the authority to refer, admit and discharge within appropriate clinical areas. Working as part of the multidisciplinary team, ANPs can work in or across all clinical settings, dependent on their area of expertise (NMC, 2016).

There are a number of different definitions for the term ANP used by various health bodies, it is important to clarify my definition in this thesis from the outset.

The International Council of Nurses (ICN) refers to ANPs as follows:

> A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice (ICN, 2018).

The Career Framework for Health (CFH) describe ANPs as:

> Experienced clinical professionals who have developed their skills and theoretical knowledge to a very high standard. They are empowered to make high-level clinical decisions (CFH, 2010).

Furthermore, the Nursing and Midwifery Council (NMC) define an ANP as a practitioner who:

> practices autonomously within his/her expanded scope of clinical practice and demonstrates highly developed assessment, diagnostic, analytical and clinical judgement skills (NMC, 2014).

While these descriptions reference the duties and responsibilities of ANPs, none of them explicitly specify their role in managing risk. Managing risk and patient safety

is the specific focus of this study. Nevertheless, Health Education England (HEE) used the following wording in defining Advanced Practitioners as:

> experienced professionals who have developed expert knowledge base; use and build the evidence base; demonstrate complex clinical decision-making skills; manage risk; continually learn and facilitate learning for others; innovate to deliver sustainable improvements in patient care; exhibit proactive leadership to transform services; understand local and national contexts of healthcare; work across boundaries (NMC, 2014).

This description draws on similarities between the definitions from the ICN, CFH, and NMC and it is its' inclusion and thus recognition of risk management that aligns itself with the focus of this study. The HEE recognize that this description is a work in progress referring to a *journey* of an evolving definition.

In 2017 a new framework was set out by NHS England for Advanced Clinical Practitioners (ACPs). This role which encompasses other non-medical professionals as well as nurses, is defined as

> a registered practitioner with an expert knowledge base, complex decision-making skills and clinical competencies for expanded autonomous scope of practice, the characteristics of which are shaped by the context in which the individual practices (HEE, 2017).

Thus, autonomy is considered a defining feature in which competency dictates the boundaries of their advanced practice (Imison and Bohmer, 2013). For clarity, this research is looking at ANPs to retain a focus on the profession of nursing. It should be noted that the use of the term ANP in this thesis, is inclusive of Autonomous Practitioner and Emergency Nurse Practitioners (ENP) which are often used synonymously with ANP to signify a level of practice denoting clinical competencies and advanced training and education.

2.3 The Policy context and the evolving role of ANPs

It is important to briefly explore the historical development of the ANP role in order to better understand the context of today's practitioners. ANPs are at the forefront of policies to modernise the healthcare workforce both nationally and internationally (HEE, 2016). This is as a result of a political drive for cost effective healthcare and has led to an increase in the expansion of non-medical roles (Abraham *et al.*, 2016). Influencing factors of the development of UK ANPs were to reduce healthcare costs and improve healthcare access at a time of a declining number of doctors (Pearson and Peels, 2002). Early policy drivers of the ANP role arose out of the NHS Plan service redesign to enable a flexible healthcare provision including restructuring of role boundaries between medical and non-medical practitioners (DH, 2000).

The title ANP has been described as an umbrella term to describe advanced nursing roles (RCN, 2012). A survey of thirty-two countries identified thirteen different titles (Pulcini *et al.*, 2010). Confusion and wide variation remain with regard to standardisation of title, roles, scope of practice and educational preparation (Hoskins, 2012). Interestingly, one study found the diversity of ANP scope of practice to be related to individual competence and preference of medical colleagues (Maddox *et al.*, 2016). Globally, ANPs are regulated by three mechanisms: a professional body, nationally by central government and locally by employers. In the UK they are further regulated by local procedures such as clinical governance approaches (King, Tod and Sanders, 2017). Therefore, employers can also make decisions about scope and preparation of practice. This raises issues such

as variations in scope, organisational constraints and lack of support. Such lack of role clarity has serious implications for the future of ANPs.

Educational preparation of ANPs differs not only between countries but also between independent programs in the UK (Heale and Rieck Buckley, 2015). Master's qualification is a minimum in many countries and there is a growing opinion that it should be a future requirement in the UK (Reynolds and Mortimore, 2018; RCN, 2012), though this is not the case currently (King, Tod and Sanders, 2017). Certainly, the ANPs deemed worthy of inclusion in this study did not all have a Master's Level education, particularly those who had been practicing long before this standard. Indeed, one survey found that under one third of ANPs had a Master's degree (Gerrish *et al.*, 2011). Pre-registration nursing courses increasingly have advanced skills in their content, particularly those at Master's level, arguably leading to further blurring of boundaries between junior and advanced nurses. The RCN has developed a framework of competencies and introduced credentialing where ANPs can formally log their experience, competence and qualification. However, this training is not a requirement of ANP practice and not all nurses are members of the RCN. The Royal College of Emergency Medicine (RCEM, 2015) has developed a competency-based training program for Advanced Clinical Practitioners (ACPs). Whilst supported by the RCN, it is regulated by the medical profession raising questions of who ANPs should be regulated by. The HEE ACP National Framework (2017) aims to overcome these obstacles in setting out recommendations for the development, implementation and evaluation of advanced clinical practice by defining core capabilities and identifying a standard of education. The HEE is exploring a directory and credentialing of ACPs through

mapping apprenticeships to level 7 Master's programs (HEE, 2017). These will be standardised nationally rather than the current situation that demonstrates wide local variation. Standardisation of education, role preparation and scope of these new advanced practitioner's is imperative in today's healthcare environment.

The policy context of this piece of work sits within Urgent and Emergency care, namely the *Five Year Forward View* (DH , 2014), the *NHS Long Term Plan* (DH, 2018) and ultimately within the national policy agenda of Health Education England (HEE 2017) with regard to the preparation, education and support of ANPs. The *Five Year Forward View* set out the redesign of emergency and urgent care by improving out of hospital services to provide safe, sustainable high-quality care closer to home and avoid hospital attendances and admissions (DH, 2014). Policies regarding care provision and workforce planning led to the development of the ANP role and services such as urgent care and walk in centres aiming to provide responsive services for patients promoting self-care, timely, accessible advice and treatment. The ultimate aim was to reduce ED waiting times and to connect urgent and emergency care services to improve quality and safety in healthcare. Specific policy strategy documents such as *Improving Quality and Safety in Health Care*, *Assessing and Responding to Patient Risk and Learning from incidents* are key to their implementation and go some way towards tackling challenges in this area (DH, 2014). In 2018 the government published the *NHS Long Term Plan* (DH, 2018) aiming to build an NHS fit for the future. The stated aim of this strategy is to help young patients get the best start, for communities to live well and for people to age well. The workforce planning policies of this Long Term Plan features the development and incorporation of the ACP role and the service planning involves

Urgent Treatment Centres to provide extended hours and standardisation of services to patients (DH, 2018). ANPs and other practitioners are continually responding, as well as adapting their role and practice to meet changing standards and targets. For example, there is currently a proposed trial of new ED standards which may replace the four hour wait target. If deemed a success in the fourteen EDs chosen to participate in the trial, these new standards could be rolled out across the UK in 2020 (Illman, 2019). Policies such as these aim to help frontline staff to provide effective, safer and faster care, yet the impact of how this is experienced by staff such as ANPs needs to be further explored. Though it is stated that the *NHS Long Term Plan* has been developed in partnership with frontline staff, patients and their families (DH, 2018), it is questionable whether the reality of managing risk and patient safety from the experience of ANPs is currently fully understood.

Practitioners working in acute environments make critical decisions about patient care in the course of their work (HEE, 2016). Due to staff shortages and financial pressures within healthcare, ANPs are more frequently being put in the position of primary care provider for patients (Pirret, Neville and La Grow, 2015; Rasmussen, 2012; Bowen, 2008; Ritter, 2003; Burman *et al.*, 2002; Offredy, 1998). In this role, ANPs are regularly required to make rapid decisions regarding the risk and safety of patients (McDonnell *et al.*, 2015).

Traditional role boundaries are blurring, particularly those between ANPs and doctors (Anderson, 2017). It may be considered that ANPs are situated in a grey area between the traditional roles of nursing and medicine. Advancement of these roles within an increasingly risk aware healthcare context has led to an essential focus on evidence-based medicine and implementation of protocols and other

linear guidance to support practitioners in decision-making to maximize patient safety (NICE, 2016). Some argue that this has led to a healthcare service dominated by positivism (Welsh and Lyons, 2001).

2.4 Scandals and Loss of Public Trust Lead to a Change in Policies

There is much policy discussion towards the growth of evidence-based practice in health provision (Bolt and Huisman, 2015). This has been driven by national and global concerns with patient safety and risk within healthcare. A pivotal turning-point in the UK came in the aftermath of the Alder Hey scandal, where it was discovered that organs from deceased babies had been harvested without parental permission between 1988-1996 (Hutchison, 2016). Similarly, in a Bristol hospital, thirty-five babies died following heart surgery over a ten-year period, others were brain damaged and one hundred and seventy babies may have survived if operated on in a different hospital. Failings were attributed to staff shortages, poor leadership, a culture of secrecy and lack of monitoring (Hutchison, 2016). As a result of this, there were systems of safety, increased monitoring and audit controls were put in place (Smith, 2010). Very recently, the Gosport scandal saw four hundred and fifty lives prematurely shortened through the administration of dangerous doses of opioids (Moffat, 2018). Well publicised failings such as these has led to increased concerns about patient safety and risk within the policies of healthcare systems themselves. Furthermore, this has led to a shift in the perception that health-care policy should sit within a positivist paradigm and reframed within the post-modernist world of the audit society (Power, 1997). With

this focus shift, accountability and evidence-based practice has become sacrosanct (Cummings, 2012).

Loss of public trust and a call for transparency are both impactful not only for patients but for those clinicians working in what Burton and Wells (2016) suggest is a hostile media climate. Furthermore, Cooke (2016) contends that these incidents led to a *blame culture* towards practitioners whilst directing responsibility away from organisations, managers and politicians. Arguably, this culture is impactful on all these stakeholders. The primary concern of this study is how, in this context, ANPs experience managing risk and patient safety.

2.5 The New context of Risk and Patient Safety

Patient safety and managing risk is a public priority and has increasing emphasis in health policy and in the Department of Health's' publications (DH, 2013, 2012, 2010, 2002). The literature defines risk in multiple ways. Indeed, the concept of risk has been defined and understood from multiple perspectives, from psychologists and sociologists (Crossley, 2000), global trading (Boden, 2000) and workplace health and safety (Tombs and Whyte, 2013). From a medical perspective, the British Medical Association (BMA, 2007) suggests that "risk is the probability something unpleasant will happen".

Runciman et al (2009) offers an understanding of risk as the probability that an incident will occur. Indeed, risk is understood by some as the psychometric balancing of probabilities (Bourne and Robson, 2009; Giddens, 2002). Similarly, probability is the first of two defining elements of risk according to Berry (2004), the second being a negative or hazardous aspect of concern. For some, this

psychometric understanding of risk is referred to as a common-sense approach to estimating risk probabilities (Bourne and Robson, 2009) suggesting a relatively value-neutral stance.

Rhodes (1990) distinguishes between approaches to understanding risk as the product of individual cognitive decision-making and those that view risk as the product of social interactions. Indeed, the concept has also been described as socially constructed (Lieberman, 2001). The social representation theory understands risk as a social process as well as one of rational decision-making (Zink and Leberman, 2001). The theory states that risk is based on social relations which involve partial and incomplete discourses, decisions are made which privilege some ideas/relationships and ignore others. Indeed, Mythen and Walklate (2006) contend that *risk* is a ubiquitous issue that stretches over a range of social activities, practices and experiences. These disciplinary views certainly offer an understanding of risk within different contexts. However, within the literature there is little from the perspective as experienced by ANPs working and rapidly advancing their practice in the context of today's healthcare.

Patient safety is the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum (Runciman *et al.*, 2009). The term *unnecessary* suggests avoidable and may imply fault or attribute blame. Runciman *et al. (*2009) argue that an understanding of patient safety has been compromised in the literature due to inconsistency of language. Some examples are near misses, close call, medical error, harmful incident, adverse even. All such actual or potential errors increase risk, even if an incident does not actually occur (Phillips, Stargatt and Brown, 2012; Welsh and Lyons, 2001; Reason, 1990).

Both concepts of risk and patient safety are two concepts closely intertwined in today's healthcare. The term *risk* may be considered contentious, highly politicised and value laden (Douglas, 2009). Thus, inclusion of the term *patient safety* in this study endeavoured to counter-balance this and achieve a more holistic view of this phenomenon.

Risk-management is a contemporary concept developed to reduce the chances of patient harm and poor practice (Klein and Pulliam, 2009). Beck (1992) referred to a risk society, defined as "a systematic way of dealing with hazards and insecurities induced and introduced by modernisation itself". The modern view is that risk is artefact, measurable, knowable and calculable (Giddens, 1994). Reddy (1996) refers to the 'myth of calculability' and challenges this implication that risk is controllable. Calculating risk and choosing subsequent courses of action is itself infused with risk, as customary patterns of responding to the world are challenged (Giddens, 1998). However, Beck (1992) and Giddens (2002, 1998, 1994) have argued that risks in *late* or *postmodernity* are characterized by their global nature, uncertainty.

Traditional classical definitions of risk refer to expectations, probabilities and potential loss. The natural sciences favour a theoretical approach to risk that defines and calculates, whereas the social sciences take a sociocultural paradigm that examines how risks are socially constructed (Bialostok, 2015). Beck (1992) and Giddens (1994) *risk society* offers a contemporary theory of risk. The cultural approach is where risk is viewed as a social invention with the intersection of values, beliefs and perceptions. This is associated to Foucault's (1991) governmentality approach in which the language of risk is being used to shape and

regulate economic, social, and personal activities. Whilst each of these theories of risk has a specific application, it is felt that the *risk society* viewpoint resonates with the contextual position of ANPs working in the complexity of today's healthcare.

The clinical priority of risk and patient safety nationally and internationally and the rise of patient litigation (Pearson, Steven and Dawson, 2009) is compounded by mistrust of experts, and concerns about lack of accountability and/or misuse of self-regulatory powers (Ilangaratne, 2004). This has created a sense of insecurity and perceived lack of control within modern societies (Giddens, 1994). Healthcare organizations have been given key indicators against which performance will be tracked via inspections; the aim of this is to provide greater transparency to the public (Bevan and Hood, 2004). Additionally, professionals are expected to be explicit about their individual processes of accountability, auditing of their performance, and transparency of risk-minimising procedures (Trinder, 2008).

The heightened awareness of patients and practitioners to potential risk and errors has led to increased measures of control such as standards and protocols. Indeed, Giddens (1998) contended that the increasing preoccupation with safety and the future generates the notion of risk. This has led to a changed moral political climate towards risk such as scaremongering or cover up. When addressing the lived experience of managing risk for ANPs, consideration of the impact of this risk *society* context is imperative.

2.6 The Role of Evidence-based Policy and Guidance

The traditional approaches to minimising risk in healthcare has been to standardise care through evidence-based guidance (Woolf *et al.*, 1999). Studies addressing the effectiveness of protocols and guidelines in reducing risk and enhancing patient safety are wide, varied and essential to achieving standardised, effective and evidence-based healthcare provision (Ghosh *et al.*, 2012; Rasmussen, 2012). In the area of risk management, studies assessing the effectiveness of decision-making tools, such as psychiatric risk assessments, are numerous (Phillips, Stargatt and Brown, 2012; Welsh and Lyons, 2001). An example of this is the National Institute of Clinical Excellence (NICE) in which regulated, evidence-based clinical guidelines based on rigorous research to aid clinicians to manage clinical risk and enhance patient safety.

2.7 Challenges to Existing Evidence-based Policy Protocols

In managing risk and patient safety, evidence-based guidelines are uncontestably invaluable in healthcare (NICE, 2016; Trinder, 2008; Bevan and Hood, 2004; Woolf *et al.*, 1999). However, increasingly ANPs are expected to make diagnostic, treatment, and management decisions in an environment bound by uncertainty for which they are held accountable (RCN, 2008; Albarran, 2006). These decisions are often made with limited knowledge or conflicting facts (Lyneham, Parkinson and Denholm, 2008). Furthermore, situations are more complex or uncertain than linear guidance can prepare for, thus requiring a higher level of judgement. Whilst it is imperative that ANPs, and clinicians in general use evidence-based practice to inform practice, there is a need for further acknowledgement of the uncertainty

and complexity of healthcare. Increased recognition is also required in progression towards nursing expertise which may involve applying differing models, such as non- linear judgments. Indeed, literature exists which suggests that decisions can be more comprehensive when non-linear processes work alongside linear guidance in a complementary fashion (Ghosh *et al.*, 2012; Phillips, Stargatt and Brown, 2012).

Much research has looked at the efficacy of these linear procedures, with it being commonly accepted that the use of standardised procedures does improve patient safety (HEE, 2017; NHSE, 2016; NICE, 2016), particularly when faced with uncertainty or in assisting less experienced practitioners in making safe decisions. This evidence-based guidance not only enhances the safety of patients but also of ANPs, protecting them professionally in the current litigious climate. However, the assumption that risk can be and is managed through linear guidelines alone does not consider how these guidelines are applied or how other processes may be used. Some studies show a varied degree of practitioner adherence to protocols according to their intuition or gut feelings and sight reasons such as for patient benefit or preference, or other contextual factors (Ghosh *et al.*, 2012; Rasmussen, 2012). Other studies have revealed that experts transcend reliance on guidelines that are typical in novice nurses (Lyneham, Parkinson and Denholm, 2008; Burman *et al.*, 2002; Benner, 1984). These studies suggest protocols and tools alone may not be the complete answer when making decisions involving risk. Thus, while linear guidelines and protocols are clearly imperative for standardising care and ensuring a degree of quality, it is also recognized that the reality of practice cannot always be reduced to the simplicity of following guidelines. Thus, the focus of this

enquiry is to achieve an understanding of how ANPs experience risk and patient safety in the reality of their practice.

2.8 Literature Search Strategy

The literature search was a key step in evaluating the evidence for gaps and ultimately formulating the research question and design (Grewal, Kataria and Dhawan, 2016). The strategy is described below in terms of the searching the literature, search terms and inclusion and exclusion criteria used to identify literature most pertinent to this study in order the answer the question:

What is the lived experience of managing risk and patient safety for ANPs in acute settings? A phenomenological perspective.

The approach to the literature review was one that began with an area of interest and evolved naturally through the process of iterative enquiry in exploring the literature around the subject. Repeated searches of the topic over a period of time facilitated a more targeted focus as gaps in the literature started to emerge. Techniques of critical appraisal learned through the process of undertaking the PhD were incorporated to better utilise the skills and abilities of the researcher at different stages of the journey. This led to a review of the literature which encompassed elements of a traditional literature enquiry but also flexed to allow the journey to evolve to maximise a wide exploration around the topic. Moreover, this afforded the sufficient liberty to cover the scope of the multi-dimensional aspects of a complex subject area.

2.8.1 Searching the Literature

Databases were selected according to relevancy to the research area (Fink, 2013). The databases were chosen (Table 1) on the basis that they are the key nursing data bases available (Norman, 2012). This range was intended to include not only ANPs, but also other practitioners who carry out similar roles in acute environments. PsycINFO was also included to encompass mental health patients where assessments of risk are pertinent to ANP's management of risk.

Table 1: Electronic Databases used in the Literature Review

Databases	Year
MEDLINE	1996-2018
Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus Cochrane Controlled	1996-2018
EMBASE	1996-2018
PsycINFO	1996-2018
BNI	1996-2018
Ovid Embase	1996-2018
Cochraine Database of Systematic Reviews	1996-2018
Wiley Database	1996-2018
PsychINFO (EBSCO)	1996-2018
Web of Science	1996-2018
Ethos UK Theses	1996-2018
Index to Theses	1996-2018
Grey Literature	1996-2018
Websites	1996-2018

2.8.2 Defining Key Terms Stage

Vital to the search strategies is establishing the most suitable terminology for search terms in order to capture appropriate studies to address the question of this

literature review (Michie, van Stralen and West, 2011). This proved challenging due to multiple terms and much debate surrounding the term ANP. Due to the changing boundaries and evolving ANP it was deemed necessary to include practitioners of other professions. Identification of appropriate key words, synonyms and alternative terms is fundamental to success (Grewal, Kataria and Dhawan, 2016). A wide range of terms were incorporated to capture management of risk within studies of an alternative such as approaches to decision-making. Through carrying out this process, synonyms were identified and then included in subsequent searches. Strategies learnt through carrying out a previous review were used to assist in this process, such as the PICO strategy in which, problem, intervention, comparison and outcome headings guide the synonym building and formulation of enquiry (Santos, Pimenta and Nobre, 2007). The key words that emerged from this process are shown in Table 2.

Table 2: Key Words for Literature Search

Title	Role	Related to…	With the aim of…
Nurse Practitioner	Managing Risk	Professional Judgment	Safe Decision-making
Advanced Nurse Practitioner	Risk Management	Pattern Recognition	Positive Patient Outcome
Advanced Clinical Practitioners	Safe Practice	Non-linear Decision-making	No Patient Harm Mistakes Near miss
Emergency Nurse Practitioner	Dealing with Uncertainty	Gut-feeling	Enhanced Decision-making
Autonomous Nurse Practitioner	Decision-making	Semantics/ Heuristics	Effective Care
Expertise/Expert Nurses	Judgment	Tacit Knowledge	High-quality Decisions
Advanced Practitioners	Management / Treatment Decisions	Hermeneutics / Intuition	Performance indicators

The search of the databases was repeated several times over a three-year period from July 2015 to July 2018. These successive searches enabled identification of multiple key words, as shown in Table 3. A comprehensive search strategy was then developed with assistance from specialist subject librarians at the University of the West of England and a systematic review specialist. The final search terms were adapted for each database with filters applied, following (Higgins and Green, 2011).

Table 3: Final Search Terms Used for all the Databases

ANP Or any practitioner	Nurse Practition* or NP or Advanced Nurse Practition* or ANP or Autonomous Nurse Practition* or Emergency Nurse Practition* or Advanced Clinical Practition* Practition* expert or expert nurse* or practition* Or clinician or expert* or doctor* or physician* or "clinical expert"
AND Risk and safety Risk Safety	AND Risk or "clinical risk" or "Risk management" or "Risk-management" or "managing risk" "managing-risk" or litigation or clinical error or near miss OR patient safety or safety or safe practice or safe decision making or positive patient outcome or no patient harm or patient harm or effective care or high-quality decision* or performance indicator*
AND linear Non-linear Decision-making Non - linear Decision making	AND "non-linear" or "non-linear" or intuit* or heuristic* or gut-feeling* or "feeling based" or "feeling-based" or "gut feeling" or pattern-recognition or "pattern recognition" or "non-linear decision making" or semantics or "tacit knowledge" or "tacit-knowledge" or hermeneutics or "decision making" or "decision-making" or decision* or judgment* or "professional judgment*" or "clinical judgment" or "clinical-judgment" or "clinical decision making*" or "clinical decision-making*

Linear	or Linear or “linear decision making” or “linear decision-making” or “Evidence* based practice” or EBP or evidence*-based-practice or protocols or templates or proforma* or guidelines or guidance or “clinical guidelines” or “group directives” or “flow chart”
Clinical setting	“Emergency care” or “acute care” or Urgent Care” or “urgent care centre” or “minor injury unit*”

2.8.3 Inclusion and Exclusion Criteria Stage

A review of the accessed literature was carried out independently with some support from library specialist assistance. The research strategy involved eleven electronic databases, grey literature, google, websites and social media (Cooper *et al.*, 2018), hand searching such as referencing tracing (Chapman, Morgan and Gartlehner, 2010), and direct author contact for new reference leads. Due to the specific nature of the subject of enquiry, and the number of less relevant studies, it was deemed necessary to develop inclusion and exclusion criteria to determine those studies to be included in the literature review. Firstly, published studies relating to management of risk and patient safety regards clinical judgment of clinicians working in urgent or emergency care were included. Then, studies published in English were selected. To capture relevant studies relating to the phenomenon, the criteria were set widely to include all clinicians. To encompass the whole spectrum of approaches in managing risk, specific terminology relating to both non-linear and linear approaches were also included. As the remit of this review was to look at autonomous practitioners making decisions independently regarding risk and patient safety, exclusion criteria included studies of nurses who were neither advanced practitioners, nor working autonomously. The search was

conducted by both title and abstract. The final inclusion and exclusion criteria are shown in Table 4.

Table 4: Inclusion and Exclusion Criteria

Primary Inclusion Criteria	Primary Exclusion Criteria
● Written in English language ● Qualitative, quantitative or mixed methods research ● Covering period 1996-2018 ● Advanced Nurse Practitioner/ Autonomous Healthcare Clinician/ /Doctor ● Located in acute or primary care setting in clinical setting/in practice/front line setting/Urgent Care/ED ● Abstract reference to non-linear clinical reasoning, linear processes, and recognised synonyms for decision making	● Non-clinical setting ● Secondary or long-term care settings ● Non-healthcare practitioner ● Non-advanced/non-autonomous practitioner
Secondary Inclusion Criteria	
Included within the abstract: ● Risk and patient safety ● Reference to linear/non-linear decision-making processes ● Protocols/guidance/decision support systems	

2.8.4 Data Appraisal Evaluation Stage

Once the key studies were identified (n=11), a data evaluation stage was conducted to ensure items were worthy of inclusion.

In order to evaluate the studies the Critical Appraisal Skills Program check list was used (CASP, 2016), see Appendix 1. The CASP tool was incorporated with Meyrick's (2006) quality framework for assessing qualitative research (Appendix 2). These frameworks were chosen as they complement each other providing a sound

and coherent structure through which to quality appraise the studies to ensure that all aspects of both qualitative and quantitative studies were addressed. The addition of Meyrick's assessment of qualitative research framework added increased depth by addressing the researchers' epistemological theoretical stance, bias, and researcher reflexivity (Knowles and Gray, 2011). Meyrick's (2006) structured headings - Systematic and Transparent - provided additional clarity in application of this framework of critique as shown in Table 5.

Table 5: Combined CASP/Meyrick Quality Appraisal Framework

Collective Criterion of Quality Appraisal	
Systematic	*Transparent*
Clear Aim	Participant/ Researcher Relationship
Method Appropriate	Ethical Issues Addressed
Research Design Appropriate	Value of the Research
Recruitment Strategy Appropriate	Researcher Epistemological
Rigorous Data Analysis	Theoretical Stance
Clear Statement of Findings	Bias
	Researcher Reflexivity Objectivity

A table summarizing the eleven key studies identified through this process can be found in Appendix 3.

2.8.5 Analysis and Interpretation Stage

The retrieved studies were synthesized through a quality appraisal process and data extraction forms (See Appendix 4 for an example). This process of data extraction and appraisal provided me with an indication of low, medium and high quality of each study alongside an in-depth understanding of each study. From this

analysis and interpretation, gaps in the evidence were identified were identified and themes emerged.

2.9 Synthesis and Discussion Stage

Following the synthesis of the literature, the following themes emerged:

- Application of Evidence-based Practice
- Dealing with uncertainty and complexity
- Non-linearity reasoning in nursing
- Non-linear and linear interface
- Risk tolerance and patient safety
- The reality of risk management
- Expertise knowledge and training

These themes form the structure of the discussion.

2.9.1 Application of Evidence-Based Practice

The use of evidence-based practice (EBP) was introduced for standardized, high quality patient care and are widely recognized to reduce risk and enhance patient safety (Carayon, 2017; HEE, 2016; NICE, 2016; DH, 2015; RCN, 2008). The advantage of research informed guidelines from national and international bodies is standardised, good quality, effective and safe care (Carayon, 2016). However, if the approach to safeguard the management of risk relies on strict adherence to evidence-based guidelines and protocols regardless of contextual factors, then the

findings of Rasmussen's (2012) qualitative ethnographic study reveal that this does not always take place; abandonment of protocols/guidelines emerged as a theme.

Rasmussen (2012) used single case methodology, including non-participant observation, informal conversations, interviews and document reviews to examine the perspectives of forty-nine clinicians to protocol-led management of the risk of Clostridium Difficile risk in an acute hospital. The findings suggest that participants abandoned protocols and guidelines during decisions and relied on experiential knowledge, common sense, intuition, "rules of thumb" and "mind lines" to guide their practice. The analysis of data identified that, through heuristics, guidelines were "worked around" and improvised as staff struggled against organizational constraints, unrealistic, conflicting priorities, and protocol ambiguity. Rasmussen (2012) also emphasized patient preference as being a key contextual challenge when following protocols rigidly.

The limitations to Rasmussen's study are regarding validity and reliability of informal conversations in data collection and how this was standardized amongst the researchers. Potential inconsistencies raise issues of trustworthiness, and the validity of criteria for inclusion of this informal data may be questionable. The focus of this study was practitioners self-reporting on guideline adherence, but it remained unclear whether specific outcomes were assessed. Rasmussen used Miche *et al.'s* (2005) topic guide theoretical framework of behavioural change to conduct the interviews, yet acknowledged that this framework had limitations in that it did not take into account tacit and experiential knowledge. Positivists contend that the case study approach is a weak method for lacking rigor and generalisability and are prone to bias (Jensen and Rodgers, 2002). Case studies can

also lead to an enormous amount of unmanageable data. Nevertheless, it could be argued that Rasmussen's prolonged researcher engagement of eight months in the field and the large number of participants enhanced the credibility of the data (Lincoln and Guba, 1985). Rasmussen also used multiple data for triangulation, which is an accepted method of enhancing trustworthiness as it adds to the jigsaw puzzle of knowledge (Breitmayer, Ayres and Knafl, 1991). Indeed, the different forms of data collection that Rasmussen used may have reduced some elements of subjective self-reporting however, consequences were not explored. Aside from these limitations, Rasmussen's (2012) study provides a unique insight into the inner workings of decision-making in the context of risk and suggests that the process is multi-faceted and that clinicians rely on various sources. Arguably the findings from Rasmussen's study reveal that abandonment of protocols and favouring of non-linear processes when dealing with risk by clinicians is worthy of further investigation.

In another study, Ghosh *et al.* (2012) aimed to quantify the impact of the NICE head injury guidelines (NICE, 2007). This was a retrospective case note review of the management of three-hundred and ninety-four head inured children who attended an ED in 2007. As part of the data collection, the number of CT scans performed was recorded, and a calculation made of how many would have been requested had the NICE (2007) guidelines been applied. Findings were a threefold increase in CT scans when following the NICE guidelines. Twenty-five (6.7%) had CT scans and forty-seven (12.7%) would have been scanned had the hospital guidelines been rigidly followed and seventy-four (19.7%) children would have had head CT scans if the guidelines had been adhered to. This study was robust in

terms of the large sample, including all head injured children. Ghosh *et al.* (2012) speculated that the reluctance to scan children presenting with relatively "soft" criteria may be due to clinicians' concerns about exposing a developing brain to radiation, thus balancing one risk against another. Indeed, guidelines whilst reducing risk, can lead to unnecessary hospital transfers, over-investigations and unnecessary admissions, and increased costs (Haycox, Bagust and Walley, 1999). Sajjanhar (2011) contended that less experienced clinicians rely on guidelines, admission criteria, clinical theory and second opinions to achieve safe decisions, and concluded that guidance combined with experience and clinical expert judgement is invaluable for achieving safe patient care.

Rasmussen (2012) and Ghosh *et al.* (2012) both recommended further research was needed to understand the challenges of adopting practice guidelines. Public employee rule-breaking, or subversion has been attributed to organisational factors and structures (Borry, 2017) such as performance pressures (Tummers *et al.*, 2015). Examples of *passive resistance* are minimal documentation or ignoring organisational rules (Street, 1992). Battmann and Klumb (1993) refer to the interactions of the individual with the organization in terms of consideration of perceived risks and benefits to themselves or the patient.

Hutchinson's (1990) grounded theory study used in-depth interviews with twenty-one nurses from four clinical areas to explore how nurses bend the rules for the sake of the patient. They identified *responsible subversion* based on certain conditions, knowledge, ideology and experience. Reasons given for subversion were patient advocacy, stress reduction and regaining control over their work (Hutchinson, 1990). *Responsible subversion* is attributed when it is considered best

nursing judgement is being used (Udod, 2014). Similar terms are: creative *insubordination* (Haynes and Licata, 1995) positive deviance (Carey and Foster, 2011) and *street level workers* (Meyers and Vorsanger, 2003). From the literature, conflict happens when guidelines are not perceived to meet a specific patient situation (Hupe and Buffat, 2014; Sager *et al.*, 2014; Brodkin, 2012; Prior and Barnes, 2011; Maynard-Moody and Portillo, 2010). Indeed, it is contended by some, that the modes in which *street level bureaucrats* implement policy tend to be influenced by the tensions they experience by opposing demands of patients and policies (Hupe and Buffat, 2014; Sager *et al.*, 2014; Brodkin, 2012; Phillips, Stargatt and Brown, 2012; Prior and Barnes, 2011; Maynard-Moody and Portillo, 2010; Hutchinson, 1990).

It is recognized that systems and processes put in place to enhance safety can introduce new harms if examining the wrong problem or using the wrong approach (Carayon, 2016). Rasmussen, (2012) and Ghosh *et al.'s* (2012) conclusions emphasized the value of intuition in achieving *safe* clinical decision when combined with guidance. Benner and Tanner (1987) argue that clinical judgment enhanced by intuition is what distinguishes expert human judgment from the decisions that might be made by a beginner or by a machine. Thompson (2009) argues that evidence-based technological decision-aids may not help nurses' decision-making due to their predilection for finding ways of working with uncertainty that avoid quantifying uncertainties. This is questionable and additionally does not acknowledge the security and enhanced safety that guidance provides, particularly for novice ANPs (RCN, 2018; NMC, 2014;). Furthermore, this assumption that nurses choose and have a preference for how they deal with this uncertainty is an

over-simplification of the processes involved for practitioners working in and responding to increasingly complex environments. Schon (1984) describes the complexity of professional practice as the “swampy lowland, messy, confusing problems that defy technical solution”. Similarly, Sayegh, Anthony and Perrewé (2004) wrote, "Such a neat and clean conception of human decision-making is admittedly attractive”. Concerning ourselves only with a linear, cognitive process may not seem as 'messy' as that which includes emotions.

These studies do not dispute the fact that clinical guidance is imperative to enhancing safety and reducing clinical risk. Indeed, they provide indirect evidence of how practitioners are managing risk and navigating guidance. These studies also highlight the complexity and uncertainty of healthcare environments. However, within these studies, there is little evidence of how the management of risk and patient safety is experienced in the reality of ANP practice. It is this gap in knowledge that the author’s study aims to fill.

2.9.2 Dealing with Uncertainty and Complexity

Due to the nature and context of the work of clinicians in acute settings, managing risk and dealing with uncertainty is inevitable (NMC, 2014; RCN, 2008). Indeed, Lyneham, Parkinson and Denholm (2008) state that it is the norm for emergency clinicians to make decisions with limited knowledge or conflicting facts. In support of the above studies (Ghosh *et al,* 2012; Phillips, Stargatt and Brown's 2012, Rasmussen, 2012, Welsh and Lyons, 2001) use of heuristics and intuition has been attributed to conditions where there is a sense of uncertainty (Croskerry, 2003; Cioffi, 2001; Beresford, 1991). This sense of uncertainty is particularly, although

not exclusively, present in emergency situations where there are many “unknowns” in patient assessment (Halter *et al.*, 2010). Lyneham, Parkinson and Denholm (2008) believe that the limitations to the amount of information that can be considered at one time may be what results in the application/integration of informational shortcuts or heuristics being used to close the gaps. This is, of course, dependent on contextual factors such as time, business, experience, physical and emotional state of clinician.

Welsh and Lyon's (2001) exploratory case-study aimed to investigate how psychiatric nurses conducted risk assessment through using formal knowledge, such as standardized measures, in conjunction with other forms of knowledge to guide holistic care-planning. Data from twenty-nine risk assessments and eight interviews identified three themes: use of research knowledge, tacit knowledge, and experienced practitioner skills. While cause and relationship was not studied, this study suggests that when evidence is unclear, standardized risk assessments can only form part of a holistic risk assessment, as most measures do not reflect the dynamic nature of situations, and tacit knowledge is influential in clinical judgment in complexity. Thus, the risks involved within an uncertain environment are not managed solely through rule-bound protocols but are also supported through complimentary approaches. These findings support Ghosh *et al.* (2012) and similarly Rasmussen's (2012) ideas that protocol abandonment occurs when dealing with the complexity of clinical settings, the clinicians perception of risk, social norms and other contextual issues. Despite the limitations, especially regarding the age of the study, I believe this study is relevant in terms of its direct focus on the topic of this enquiry and the insights that link it in with later studies,

such as Ghosh *et al.* (2012) and Rasmussens (2012). They reveal that practitioners use various sources of knowledge outside the prescribed protocols and guidelines, particularly in situations of ambiguity and complexity of clinical presentation.

Phillips, Stargatt and Brown's (2012) Australian study which aimed to examine the predictive validity of unstructured clinical risk assessment tools and associated risk factors for aggression in an acute psychiatric facility reports similar findings to Ghosh *et al.* (2012) and Rasmussen (2012). Phillips, Stargatt and Brown's (2012) review of the clinical notes one-hundred and ninety-three patients carried out over a three-year period identified that the risk assessment tool was only accurate at predicting some types of aggression. These results indicate that the structured risk assessments were effective in identifying risk in some, but not all, areas. Thus, this study did not provide a complete picture of potential risk. Therefore, they suggest that a further assessment is needed to capture the whole. Rather than using solely linear methods, clinicians also applied unstructured clinical methods of judgement based on knowledge, expertise, experience and intuition (Phillips, Stargatt and Brown 2012). This demonstrates a link between intuitive judgments and managing risk.

Phillips, Stargatt and Brown's (2012) speculated that it is possible that, unlike aggression towards others (*other-directed*), self-harming behaviour is heavily dependent on environmental factors and that admission to the inpatient unit removes these triggers from the individual's environment. This study was considered to be high quality as scored by the set criteria of Meyrick (2006). However, this study has limitations due to a lack of a clear definition of the term *unstructured risk assessment.* Retrospective case reviews do not explore insights

from the practitioners themselves. Whilst this study provides empirical evidence into the way in which risk is managed through the use of both structured and unstructured approaches, it seems that further insight into which processes are informing decisions around experiences of managing risk and patient safety, particularly when faced with uncertainty, would be beneficial.

These studies provide collective evidence that practitioners use a range of formal and non-formal processes and sources and that linear protocols are only part of the picture of how risk and patient safety is managed in practice. In fact, it is clear that practitioners use a range of formal and non-formal processes and sources in their roles. Thompson (2009) believes nurses should be trained in responding to uncertainty rather than certainty; including reflective dialogue (Diekelmann, 2004) critical-thinking, hypothesising and intuitive decisions (Kosowski and Roberts, 2003) to aid with dealing with inevitable information gaps (Perez and Liberman, 2011).

It is argued that in conditions of uncertainty, intuitive decisions support safe patient-care (IOM, 2011). Indeed, faced with a large amount of data and uncertainty, clinicians rely on clinical-reasoning skills to make relevant decisions (Kempainen, Migeon and Wolf, 2003). Beresford (1991) identified that the application of abstract criteria to concrete situations and the existential uncertainty of the future is inherent in all decisions. Informational shortcuts or heuristics are commonplace when information is limited and decisions are necessary (Lyneham, Parkinson and Denholm, 2008). Furthermore, Hall (2002) argues that in such situations, generating more information does not eradicate uncertainty. It seems *irreducible uncertainty* contributes to variations in clinical practice (Thompson, 2009; Eddy, 1984). Perez and Liberman (2011) contend that within the complexity

of healthcare, decision-makers are left with nothing but a set of biases and heuristics, both of which are known to produce error. Nevertheless, according to Ark, Brooks and Eva (2006) in clinical dilemmas, the non-analytic process of diagnostic-reasoning may be preferred by both novices and experts. Whether this preference is a deliberate and conscious choice, or a subconscious process remains unclear. Thus, it is clear from the literature, that there is an argument that perhaps whilst guidance and protocols assist in managing risk on a particular level, when the complexity or uncertainty is high then the balance of non-linear process may outweigh the more acceptable linear processes. Indeed, in the context of uncertainty and complexity these studies demonstrate a variable approach to clinician' management of risk including the use of non-linear judgments, yet this is an area of practice that is underexplored and needs illumination though direct study.

2.9.3 Non-linearity Reasoning in Nursing

In Carper's (1978) seminal work, nursing intuition was defined as the ability of nurses to immediately perceive a situation and to respond independently to a linear reasoning process. Benner's (1984) ground-breaking phenomenological enquiry utilizing Dreyfus and Dreyfus (1986) model of skill-acquisition described the 'intuitive grasp' of expert nurses identifying a movement from analytical thinking towards expert intuitive decisions. Subsequent studies confirm intuitive decisions are informed by a synergy of knowledge, clinical-experience and patient-relationship (Lyneham, Parkinson and Denholm, 2008; Smith, Thurkettle and Cruz, 2004; King and Clark, 2002; McCutcheon and Pincombe, 2001; Broughton, 1998;

Mandin *et al.*, 1997; Polge, 1995; Benner, Tanner and Chesla, 1992; Benner and Tanner, 1987; Dreyfus and Dreyfus, 1986).

Numerous studies over the last 30 years have built on Benner and Carper's seminal work. A "sixth sense" was described in Andersson, Omberg and Svedlund's (2006) study in which they observed and interviewed nineteen ED triage nurses in Sweden. The "sixth sense" aided in prioritising patients, speculating that the term intuition was not used as it implied an instinctive method of thinking. Edwards and Sines (2008) used a grounded-theory approach. Data collection from fourteen triage nurses was through videos and commentary investigating the clinical reasoning involved in initial assessment of patients. Analysis identified an immediate, intuitive evaluation of patient appearance and comparison to a repertoire of previous cases of informed decision-making. It was not clear from the study whether this evaluation was accurate which would have been important information to inform the results of this study. Similarly, Lyneham, Parkinson and Denholm (2008) used hermeneutic phenomenology to investigate intuitive knowing by interviewing fourteen experienced emergency nurses in Australia, resulting in the reconstruction of Benner's expert stage into three phases: cognitive; transitional; and embodied intuition. This supports evidence of a link between intuitive practice and expertise.

Focusing on high-pressured decisions, Ramezani-Badr *et al.* (2009) conducted semi-structured interviews with fourteen experienced ICU nurses exploring clinical reasoning to understand decision-making in stressful situations. The themes that emerged included intuitive clinical reasoning, pattern-recognition, and hypothesis-testing. Similar findings were derived from Odell, Victor and Oliver's (2009)

systematic review, and Cioffi's (2001) descriptive study on recognising patients needing emergency assistance. Nevertheless, such ways of knowing in nursing have remained contentious. Perez and Liberman (2011) refers to concepts such as intuition as a "mystifying phenomenon" that needs to be understood. The debates around intuition argue that it is innate, mystical, cognitive, a feminine trait, or decontextualized knowledge (Darbyshire, 1994). Fonow and Cook (1991) point out that nursing experiences are socially constructed subjective phenomena and that female nurses' experiences within the patriarchal healthcare culture may be devalued or ignored. However, this hierarchy of value with regard to objective versus subjective is steeped in a historical dominance of cartesian thought and the gender associations of cartesian rationality is surely a wider issue of feminism. According to Welsh and Lyons (2001), the effects of Western logical positivism has led to a reductionist approach to healthcare which does not deal with complex health problems. Indeed, in a scientific age where linearity, determinism, and reductionism are favoured, intuitive decision-making is regarded with disdain (Perez and Liberman, 2011) and devalued against the systematic scientific approach (Welsh and Lyons, 2001). Arguably, no single system or approach can be understood in isolation. The reductionist approach separates the objective and subjective. However, in order to achieve a complete understanding of what it means to manage risk and patient safety will require a deeper comprehension of the linear and non-linear interface from the holistic perspective of those experiencing it.

2.9.4 Non-linear and Linear Interface

An interpretation of the non-linear and linear interface may be through the two systems as described in the dual processing theory. System I is described as rapid, unconscious, intuitive, and primarily a pattern recognition process involving retrieval of previous specific experiences from long-term memory and System II as hypothetical - deductive reasoning, slow, conscious, effortful, logical, systematic, and based on explicit rules such as those that govern clinical diagnosis (Evans, 2008; Stanovich and West, 2008). With a dual processing theoretical focus (Cabrera *et al.*, 2009), a prospective observational study of a convenience sample of physicians assessing patients in an ED, aimed to compare the performance of these systems in determining acuity, disposition and diagnosis through six hundred and sixty-two observations from two hundred and eighty-nine patients. Physicians with limited information were asked to predict acuity, diagnosis and final disposition (i.e. whether they were discharged home or transferred to the intensive care unit, etc.). The results for acuity demonstrated that the observers had a sensitivity of 73.9% and a negative predictive value of 85.7%; observers, when looking at final disposition, made accurate predictions 80.8% of the time; for ICU admission, emergency physicians achieved an accuracy of 33.9%. Accurate diagnoses made with limited available data, occurred 54% of the time.

From these results, the researchers surmised that System I decision-making, which was made based on limited information, had a sensitivity of close to 80% when predicting acuity and disposition. However, when predicting ICU admissions and diagnoses, performance was considerably lower. Thus, System I decision-making emerged as being insufficient for final clinical decisions in these domains.

However, System I decision-making could provide a cognitive framework for System II decision-making. Aligned to this duel processing model of reasoning there is an association that rapid diagnosis will lead to more errors due to the vulnerability of System I to cognitive biases, and thus considered error prone (Mamede *et al.*, 2010; Croskerry, 2003). This may be based on an assumption that System I is used only when making quick decisions, not taking into account when it is used to assist in complex decision-making when there is not limited time but limited information. However, this study was limited to one ED and thus confined to the specific culture of that department. This study is robust in terms of sample size and specific outcome measures and also provides important insights into the interface between System I and II. However, it was carried out with physicians rather that ANPs and, furthermore, was an observational study with limited insights from the practitioners themselves. Indeed as Croskerry *et al.* (2014) point out, reductionist approaches to investigate decision-making which isolate dependant variables may be considered artificial and thus sacrificing validity and suggest instead that in order to achieve deeper understanding in this area, the approach of enquiry should focus less on the deficiencies of intuitive and analytical systems and more on their adaptive strength.

Slightly dated but considered noteworthy is Burman *et al.* (2002) qualitative grounded-theory study which used purposive sampling with an aim of asking thirty-six primary care ANPs based in the US, through semi–structured interviews to reveal the nature of their diagnostic reasoning process through two clinical scenarios. Through constant comparative analysis, this study identified a patient-focused holistic viewpoint, and an "iterative spiral process" involving searching for

"red flags" to identify clinical risk. The main theme of diagnostic reasoning was pattern recognition within which using schemas, hypothesis testing and intuition were key parts. With findings that identify a mixed strategy approach to diagnostic reasoning, the author believes diagnostic reasoning specific to ANPs deserves further investigation. Similarly, Ritter (2003) studied ten experienced ANPs using think-aloud protocols with case-scenarios aiming to examine whether the Information Processing Model or the Hermeneutical Model or a combination of the two models best describes their diagnostic reasoning. Results demonstrated that the NP use the information processing model 55% of the time and the hermeneutic model 45% of the time. Thompson (2009) warns of the dangers of relying on intuition alone and its insufficiency for good quality decisions. The dichotomy that decisions are either intuitive or analytical does not reflect the level of analysis that nurses use (Cader, Campbell and Watson, 2005). Some authors argue clinical-decisions with possible critical consequences, should not be based on intuition (English, 1993) citing a lack of empirical evidence on the phenomena (Williams, 2001).

One of the few studies to address the area of possible negative outcomes of using System I processes was a study carried out by Pirret, Neville and La Grow (2015). The aim of this comparative research study design was to compare the diagnostic reasoning style in complex case scenarios of thirty Nurse Practitioners (NP) and sixteen doctors working in multi-specialities including ED, identified through purposeful sampling. The tools utilized were an intuitive-analytic-reasoning instrument and questionnaire. The results showed that NPs incorporated more System I (intuitive) processes when compared with doctors, indicating that

System II (analytic) processes were triggered when required. Diagnostic reasoning style and identification with maxims did not influence their diagnostic accuracy of a complex case. The uneven ratio of almost a 2:1 of NPs to doctors affects the quality of the accuracy of comparative evaluation. The background context to this study was at a time of considerable resistance to the introduction of NPs into healthcare settings in New Zealand. If the aim of the study was to address this resistance and comparing abilities, then this may have implications for how the findings are interpreted. Pirret, Neville and La Grow (2015) acknowledge that the analysis was part of a wider study, as justification for the discrepancy which suggests the participants who were recruited through purposeful sampling may have been selected for the purposes of the main study aim, which may have affected validity of results. The results do not provide absolute evidence but do indicate a preference for System I processes by NPs when compared to doctors in complex cases. Whilst findings outline an approach to management of clinical complexity and evidences comparable proficiency of NPs and doctors, it does not explicitly identify how risk and safety is directly managed.

Similarly, Pirret, Neville, La Grow (2015) and Van den Bruel *et al.s* (2012) studies reported findings of non-linear reasoning triggering a linear analytical process. This was an observational study of primary care consultations of general practitioners (GP's) and community paediatricians, a consecutive series of three thousand eight-hundred and ninety children and young people aged zero to sixteen years in Belgium. This study aimed to investigate "…the basis and added value of clinicians' "gut-feeling" that infections in children are more serious than suggested by clinical assessment". Conclusions were that a gut-feeling triggered an action or

a response such as seeking a second opinion or further investigations. The author feels, however, that Van den Bruel *et al.*'s aim lacked some clarity and was slightly ambiguous and value-based. The nature of consecutive patient presentations suggests that the sample has a degree of randomization. The method of observational study may remove some bias (Kahan *et al.*, 2014), perhaps giving it increased validity when compared to the more common self-report interview method (Hopwood *et al.*, 2008). The results demonstrated an observed association between intuition and clinical markers of serious infection; this is a potentially significant finding. The participants intuition and gut feeling indication to them that something was wrong. This was despite clinical assessments concluding that had the nurses acted and reflected on their gut-feelings, two of the six cases may have been prevented from being missed. Thus, in this study, nurses drawing on intuition may have enhanced the outcome of clinical skills or decisions made.

Offredy (2002) qualitative study with eleven GPs and eleven ANPs working in general practice used a think-aloud scenario-based interview process with the aim of comparing the diagnostic reasoning processes, conclusions were that both professions described using "non-analytic" processes of pattern recognition as their main decision-making method. However, use of the Elstein, Shulman and Sprafka, (1978) four staged reasoning process may weaken the interpretation of these results, as it seeks to linearize the process and limits the exploration of non-linear reasoning. The age of this study may also be considered to have limited application to today's clinicians, particularly with regard to a rapidly evolving healthcare culture. Nevertheless, this study was a direct comparison of NP and GPs decision-making process when given the same patient scenarios which is important because

it encompassed disciplinary differences. It is noted that this study does not involve any analysis of the cognitive processes of decision-making by ANPs thus highlighting a gap in knowledge requiring further investigation. Indeed, a recommendation of the study itself was that further research exploring the processes of decision-making by NPs needs to be undertaken in the practice setting, particularly as the role of the ANP is evolving.

Offredy (2002) identified that a non-linear process of pattern recognition tended to be the main decision-making method of both GPs and NPs. However, Bowen *et al.'s* (2014) study concluded that clinicians working in the Paediatric ED used a combination of clinical rules, "supplemented" by additional skills of observation, risk management and intuition to achieve clinical decisions in cases involving acute respiratory illness in children younger than five years of age. The growing evidence suggests that the complexity of healthcare requires a dual approach to decision-making i.e. intuition leading to escalation of response which may then be applied to protocols/guidelines (Pirret, Neville and La Grow, 2015). Conversely, this may work in reverse where protocols/guidelines are not applied in isolation with non-linear reasoning for reasons of disengagement (Rasmussen's 2012). Bowen *et al.*'s (2014) study demonstrates the difficulty in separating out the two processes. Whilst isolating each process for purposes of analysis is useful, it does not recognise the interrelationships at its essence.

It can be concluded that experienced and effective clinical decision-making requires both forms of clinical reasoning with respect to type I (non-analytical) and type II (linear). Patterns in the literature suggest that type I often precedes type II clinical reasoning. Furthermore, it would appear, that perhaps in situations of

complexity and uncertainty, then type II does not suffice, and an application of type I is necessary. Arguably, the dichotomy that decisions are either intuitive or analytical does not reflect the level of analysis that nurses use (Cader, Campbell and Watson, 2005) particularly in an environment where the doctrine of applying scientific evidence-based practice, where decisions can affect outcomes is imperative (Robert, Tilley and Petersen, 2014). Collectively, these studies, whilst partially revealing the value and contribution of multiple processes involved when managing risk and patient safety, do not provide evidence that explicitly shows how and what form this takes in the reality of experience.

2.9.5 Risk Tolerance and Patient Safety

Within the evidence, clinicians' individual capacity to tolerate risk is an important element as to how decisions are made in practice (Bowen *et al.*, 2014; Phillips, Stargatt and Brown, 2012; Offredy, 2002; Welsh and Lyons, 2001). Risk tolerance is multifaceted; one factor of which is experience or expertise. The evidence demonstrates that with experience and expertise, there is greater risk tolerance of risk associated with an increased application of non-linear reasoning (Phillips, Stargatt and Brown, 2012; Offredy, 2002; Welsh and Lyons, 2001). This was indeed the study findings of Bowen *et al.* (2014) who used qualitative interviews to examine the decision-making of fifteen paediatric emergency clinicians with an aim to confirm if more children could be managed in primary care to reduce hospital admissions. Senior clinicians were found to effectively manage clinical risk using high levels of intuition when applying guidelines to practice.

Bowen *et al.*'s (2014) study revealed some key and important evidence for this thesis in terms of risk management. However, quality appraisal, using Meyrick's criteria, identified several weaknesses. The aim of this study was to identify whether more children with respiratory conditions could be managed in the community. It is questionable whether the qualitative interviews of clinicians self-reporting on their decision-making as to whether to admit or discharge patients would truly seek to answer this question. It could be argued that a question such as this can only be answered in the community setting. Use of multiple sampling techniques is beneficial in that it accesses a wide range of participants. However, examining decision-making of non-autonomous practitioners, such as nurses without advanced practice may not be sufficiently comparable.

Bowen *et al.'s* (2014) study design appeared relatively organic in its process in terms of changing the method of sampling towards the end of the research to target participants at particular levels of experience to further examine issues relating to emerging data. Whilst this proved to enable targeted data, it is reasonable to question whether this achieved fulfilling the aim and purpose of the study. This was a study in response to the persistently high rates of paediatric admissions for respiratory illness and to assess whether they can be managed in primary care. Questions around decision-making regarding admissions remained unexplored. Greater understanding of issues from other settings such as urgent care is arguably needed. Whilst this work makes some important links between risk management, expertise, and non-linear reasoning, this is an indirect finding from a larger study with the specific aim of reducing hospital admissions; it does

not directly investigate the risk and safety issues involved. This thesis seeks to shed light upon a gap of knowledge about how risk and safety is managed within this high-pressured healthcare context.

In Bowen *et al.'s* (2014) study, two of the three main themes were related to risk. The first theme was "Perception of factors influencing decision making"; a sub theme of which was "Risk Management". Bowen *et al.* (2014) concluded that central to all clinical decision-making was managing risk; Risk was described by participants:

> as balancing the safety of the patient (typically ensured by admission) against the possible hazards, associated with discharge and deterioration. Clinicians initially relied on good clinical knowledge and awareness of guidelines as a foundation. Clinical experience allowed clinicians to experiment with risk and development of intuition (Bowen *et al.* 2014 p 78).

Stolper *et al.* (2011) describe an intuitive gut-feeling monitoring process that has an effective component in reducing risk. Risk tolerance is associated with the practitioner's own traits, characteristics, approach, experience, and support. Miller (1995) states that the characteristics of intuitive nurses include the willingness to act on intuition, skills, client connection, an interest in the abstract, and being a risk-taker. Perez and Liberman (2011) identifies that intuition requires supportive networks for mentorship through risk-taking activities. Interestingly, Van den Bruel *et al.* (2012) found that the strongest contextual factor for clinicians acting on their gut-feeling was the parents' concern that their child's illness was different from previous experience suggestive of the pattern recognition.

The second of three main themes of Bowen *et al.'s* (2014) study was identified as self-reported intuition, which involved clinical signs, patient

appearance and behaviour, to aid in an "Assessment of clinical severity". A clear link was self-reported between intuition, application of guidelines and managing risk, plus an association was also made by clinicians between expertise and an increased risk tolerance. Similarly, Rasmussen (2012) discussed the preferences and perceptions of risk in terms of experience and other contextual factors. Thus, the literature implied affiliation between intuition and risk this association requires further investigation.

Whilst not without limitations, Bowen *et al.'s* (2014) study provides key insights with regard to processes involved with clinicians who are balancing risk with other variables to make clinical decisions for patient safety in the context of today's clinical environment. This study builds on previous studies linking effective risk-management, level of knowledge, expertise, application of protocols or other linear decision-making tools and underlying use of non-linear clinical reasoning skills. However, understanding the management of risk was not an explicit aim of the study. Furthermore, the participants were not exclusively ANPs. Thus, it is clear that this is an area that needs to be studied directly to expand empirical knowledge.

2.9.6 The Reality of Risk Management

It is recognized that in negating one risk, either through decision making support technologies or other approaches, that new risks may be created, and safety can be compromised (Carayon, 2016). On discussing a clinical-tool to identify deteriorating patients, Stahel *et al.* (2010) emphasized the importance of combining guidelines with intuition. Indeed, the Ghosh *et al.* (2012) study findings identified less

experienced clinicians relied on guidelines to achieve “safe” decisions whist also acknowledging that for more experienced clinicians, guidance combined with clinical expert intuition was invaluable (Ghosh *et al.*, 2012; Sajjanhar, 2011). This study highlighted a potential risk of over-investigation, in this case, increased radiation when guidelines are followed alone. The literature supports the theory that intuition is not an either/or approach but can augment guidance/policy. Stolper *et al.* (2011) also argue that intuitive gut-feeling has an affective component in reducing risk when applying linear guidance.

Similarly, Ferguson, Stromberg and Celauro (2010) investigated the abilities of nine surgeons and ten trainees on estimating risk in complications of forty-eight patients having lung resections using a seven-point-scale. Findings were that experienced surgeons were more accurate than trainees in estimating risk, thus supporting the theory that expertise affords a greater understanding and anticipation of risk. Anticipation of clinical risk has also been studied from the patients’ perspective. Heiniger, Butow and Charles' (2015) qualitative study explored women’s perceived breast cancer risk. Thirty-six women from high-risk breast cancer families who had not undergone genetic testing were studied. Data suggested that participant understanding of risk relied on intuitive judgments, rather than objective cognition. Freud’s view was that in vital matters, decisions should come from the unconsciousness (Brunelli, Pompili and Salati, 2013).

Indeed, any study or understanding of risk must consider what the risk is, from whose perspective, whether the patient’s, the practitioner’s, or the healthcare organization. Whilst risk has been studied from multiple perspectives, it has not been studied directly from the perspectives of ANPs working in acute

settings. Thus, the author identifies a gap in the research that this study aims to fill.

2.9.7 Expertise, Knowledge and Training

It is clear from the evidence that achieving a level of expertise enabling a high level of reasoning is key to managing risk and safety effectively. It is also important to consider how different professionals with differing levels of education and training apply their clinical reasoning skills. A consideration of professional background, is imperative when considering how risk is managed (Ferguson, Stromberg and Celauro, 2010).

Pirret, Neville and La Grow's (2015) comparative study of diagnostic reasoning showed that NPs incorporated more intuitive processes when compared with doctors. They found that the reasoning style was not related to participant's diagnostic accuracy of a complex case, indicating that intuitive processes triggered analytical processes when required. Thus, whilst finding differences in approach, the abilities were comparable. Offredy (2002) found that decision making of NPs and GPs was comparable with similar diagnosis and treatment options and favoured the same decision-making method of pattern recognition. Pirret, Neville and La Grow's (2015) study suggests differences in approach according to profession, whilst Offredy's (2002) earlier study demonstrated a similar approach despite a differing background. It may be in contention as to whether non-linear reasoning such as pattern recognition is related to clinical experience and background dependent or whether it is the expression of the synergy of all elements.

Senior clinicians were identified by Bowen *et al.* (2014) to effectively manage clinical risk using high levels of intuition when applying guidelines to practice, thus linking expertise and increased risk-tolerance. The third of the three main themes in Bowens study was "transition to expert" i.e. experience, risk tolerance, and intuition. Thus, suggesting an expert no longer has the need to refer to the rules of practice (Lyneham, Parkinson and Denholm, 2008). However, an expert who does not adhere to rules may appear as and be considered, a risk taker.

Bowen *et al.*'s (2014) clear link between expertise, intuition, and clinical risk was also found in (Phillips, Stargatt and Brown, 2012) study where they concluded that, based on professional expertise, prior experience and intuition clinicians are relatively good predictors of other self-directed aggression in adolescent out-patient units. Ghosh *et al.* (2012) also identified that less experienced clinicians relied on guidelines to achieve "safe decisions" and concluded that guidance, combined with clinical expert intuition, was invaluable. Pirret, Neville and La Grow's (2015) conclusions were that without the application of expert knowledge, errors can negatively impact on patients' progress or outcome. Welsh and Lyons (2001) concluded from their study that experienced practitioners push the boundaries of practice protocols/procedures by using tacit knowledge and intuition as well as formal knowledge.

The conclusions of Pirret, Neville and La Grow's (2015) study imply that diagnostic errors may be less about heuristics and biases and more about knowledge, experience, and clinical expertise. However, Pirret, Neville and La Grow's (2015) study acknowledges that experts with a high level of specialty knowledge and clinical expertise still make diagnostic errors, but points out, due to

expert knowledge, that they are better at error recovery. With an international focus on reducing diagnostic error, the results of Pirret, Neville and La Grow's (2015) study, provide an opportunity to reflect on diagnostic reasoning styles and how they contribute to diagnostic error and error recovery. This has clear implications for ANP training in that new clinicians should be made aware of factors that contribute to diagnostic error as well as strategies that reduce it. Bowen *et al.* (2014) surmised that the supplementary skills of observation, risk management, and intuition develop over the course of training and are used to good effect by experienced clinicians to arrive at rapid treatment decisions.

2.10 Conclusion

ANPs work at a high level of practice and as this role evolves and is expanding, they are increasingly managing risk and patient safety. It is therefore important to create opportunities to further understand this rapidly developing practice. At an organizational level, risk is managed, and safety enhanced through the use of guidelines and protocols that seek to standardise practice though EBP and guide ANPs to practice safely and effectively.

Each study in the literature review demonstrates, to varying degrees, that guidelines alone, and thus an organizational understanding, may not provide the whole picture and the reality of experience for ANPs managing risk and patient safety. There is evidence that clinicians managing risk in clinical settings apply and value non-linear reasoning which is particularly valued when faced with complex or uncertain situations. There is an association between increased risk tolerance,

increased expertise and the perceived ability to apply non-linear clinical reasoning when managing patient safety and clinical risk.

These studies clearly identify that management of clinical risk and patient safety is an area of practice that is significant and research-worthy. However, there is little empirical knowledge or understanding from the perspective of those ANPs who are experiencing this phenomenon at the forefront of today's acute healthcare settings.

Much of the evidence around managing risk in practice is concentrated in specific areas such as paediatrics, psychiatry and surgery and also concentrated on doctors or nurses who are not ANPs. However little information exists regarding the experiences of and the realities of how ANPs manage risk and patient safety in acute settings within current health policy imperatives. Evidence demonstrates that it has either been indirectly studied or findings related to this area may have been incidental or part of an enquiry with a different focus. Collectively, these varied studies identify not only the significance and complexity of risk and safety management by ANPs, but also its elusiveness within the current evidence. Thus, ANP management of risk and patient safety practice warrants direct investigation to illuminate, explain, understand, and interpret this critical but elusive crux of advanced practice. Managing risk and patient safety is a key part of an ANP's role.

Prior to deciding on appropriate methods there was consideration of other methodologies such as grounded theory, which was disregarded as rather than to generate theory, a better understanding is needed to be achieved of this concept from the experience as it is lived from the perspectives of ANPs. It was decided in order to achieve this, that Interpretive Phenomenology (IP) would be an

appropriate methodology to capture the reality of this area of clinical practice. It is the author's belief that this understanding of the phenomenon of the experience of managing risk and patient safety can only be achieved by attempting to access the lived reality of those ANPs experiencing it. Such evidence may illuminate new horizons in this under-researched but critical area of professional practice. Achieving further understanding of this little-known phenomenon will help to prepare and support ANPs in their practice. Furthermore, increased knowledge in this area will inform todays' clinicians, tomorrow's education and training and future healthcare policy.

The proposed study is timely, as it addresses policy and public concern regarding patient safety. Empirical knowledge of risk management has grown in relation to clinical practice. However, scholarly inquiries exploring the extent to which ANP's clinical practice in making judgements related to navigating risk and promoting safety are under-researched areas. The adoption of an IP will address gaps in current knowledge, by providing an alternative methodological lens to unveil the essences and nature of the phenomena. Findings will have implications to positively impact the nursing profession, for ANP education, and development of guidelines and policies enabling effective management of risk and uncertainty for safe patient care.

Chapter Three will explicate and justify the choice of the underpinning philosophy of Martin Heidegger (1962) which guides the methodological approach subsequently discussed in Chapter Four.

Chapter Three – Underpinning Philosophy

3.1 Introduction

Following a review of the literature, this chapter seeks to address the epistemological and ontological underpinnings to justify the rationale for adopting a Heideggerian IP to address the study aim of this thesis. As a researcher in this discipline, it is imperative to be clear on my individual understanding and interpretation of Heideggerian phenomenology, particularly as with this approach, the researcher becomes part of the phenomenon (Reiners, 2012). To provide clarity for the reader, key Heideggerian terms are shown in italics.

3.2 Heidegger's Ontological Shift

Martin Heidegger's main philosophical argument was to ask the question "What is *Being*?"; a question he considered had not been deeply reflected upon since the times of the pre-Socratic ancient Greek philosophers (Strathern, 2002). In his key work *Being and Time* (1962), Heidegger aimed to explain how we understand *Being* and how, through this understanding, we develop a general ontology (theory of being) for all forms of *Being.* Heidegger developed his thoughts after examining Immanuel Kant's (1724-1804) transcendental philosophical belief that all concepts associated with space and time are merely appearances from our world of experience. Thus, in order to discover nature itself, one must first reveal the structure and rules of appearance. Blattner (2006) contended that Heidegger's adoption of Kant's ontological focus was a transformation of his own endeavour into the understanding of *Being* and the structure and rules surrounding it. In the

existing Western philosophical tradition at the time, the concept of *being* had been seen to be epistemological – related to the theory of knowledge. However, Heidegger rejected epistemology, referring to it as something that "continually sharpens the knife but never gets around to cutting" (Inwood, 1997). Instead, Heidegger embraced ontology, which marked a major break with the Western philosophical tradition of the time (Rorty, 1991; Philipse, 1998) and, in doing so, radically altered the debate on the nature of science and knowing (Corney, 2008).

Having established a theory on *Being* based on the belief that space and time are derived from our world experience, Heidegger had moved thinking on *Being* forward. However, he still felt there was much to learn from the past. Thus, even though it had been rejected by the scientific revolution and philosophers such as Francis Bacon, who believed in a systematic approach to knowledge discovery (Blattner, 2006), Heidegger returned to the work of Aristotle.

For Aristotle, the question of *Being*, was to be approached from an aetiological perspective. In other words, Aristotle was looking for the cause of *Being.* Through this process, Aristotle identified a link between "the case in the world" and "what humans correctly perceive to be the case" (Hanley, 2006). It was Aristotle's belief that perception was always interpreted and connected to an individual's experience in the world. Such views were grounded in a belief in a God and in a certain order or structure in the world, and that human-beings have a universal description or understanding of unity of the ways of *Being* (Corney, 2008). Heidegger, seeing connections between his own thoughts on *Being* and those of Aristotle, considered it essential to deconstruct Aristotle's understanding of *being*

in pursuance of setting philosophy free in order to have a fresh view on previous assumptions (Brogan, 2012). Thus, he stated:

> It is necessary to surpass Aristotle—not in a forward direction, in the sense of a progression, but rather backwards in the direction of a more original unveiling of what is comprehended by him. (1995, p.69)

However, despite an appreciation of Aristotle's philosophy, it was Heidegger's belief that Aristotle had not fully illuminated the complexity of *Being*, saying: "...even Aristotle failed to clear away the darkness of these categorical interconnections" (Heidegger, 1962 p.22/3). For Heidegger, the unity of these ways of being was not important, instead the *ousía* – the form of *being* which was the most primary sense and focus to be investigated (Hanley, 2006).

Heidegger challenged idealism (existence of ideas outside the mind) and also realism, where ideas about reality exist in reality outside the mind (Hanley, 2006). For Heidegger, without *Dasein* (human existence), Being-*there*, witnessing, things cannot be understood, may be misunderstood, uncovered, or hidden:

> As long as *Dasein* is (that is, only as long as an understanding of being is ontically possible), "is there" being. When Dasein does not exist [the proposition of independent things] can neither be understood nor not understood. In such a case, even entities within-the-world can neither be uncovered nor lie hidden. (Heidegger, 1962 p.255/212)

Thus, Heidegger's philosophy fundamentally opposes Descartes' key concept of dualism, a belief in a separation of mind and body. His philosophy also opposes Cartesian views that in order to understand ourselves, the '*I*' needs to be extracted from its environment. This led Heidegger to reject the ideal form of knowledge, as

"the world does not naturally present itself carved up in readiness for the sciences" (Inwood, 2000). In fact, referring to the separation of the physical and metaphysical Heidegger states:

> Within certain limits the analysis of the extension [the objective world] remains independent of his neglecting to provide an explicit interpretation for the being of extended entities (Heidegger, 1962 p. 134/101).

Thus, Heidegger's ontological shift towards the study of *Being* is fundamental to the phenomenological approach. In fact, it may have been this ontological shift that led to the genesis of phenomenology itself (Corney, 2008)

3.3 The Phenomenological Approach

Phenomenology has been described as an inductive qualitative research method which can be used to assemble experiences in a way that makes it easy for others to understand the world and to cultivate a worldview (Patton, 2002); as an attempt to reach the lived world (Kvale, 1994); as a method that seeks an understanding of phenomena as they appear to the person experiencing it (Borbasi and Jackson, 2011), and as being a process for investigating what something is like (Leedy and Ormrod, 2015). As the question driving this inquiry is: "What is the lived experience of Advanced Nurse Practitioners of managing risk and patient safety in acute settings?", the phenomenological approach is ideally suited.

The concept of lived experience, as expressed in the research question, dovetails with Brinkmann and Kvale's (2015) understanding of the world and their understanding of how one can reach the lived world. Borbasi and Jackson (2011)

believe that phenomenology can be used to seek an understanding of phenomena from the perspective of the individual experiencing it. Thus, from an ANP's perspective, in order to both reach and understand the lived experience of managing risk and patient safety, phenomenology is the preferred approach.

The word phenomenology is composed of two Greek words *Phainomenon* which means appearance, and *Logos* which means reason or word (Manser and Thomson, 1995). The origin of the phenomenological movement was initiated by Husserl as a radically new way of approaching philosophy opposing the positivist, empiricist conception of the world as an objective universe of facts (Mackey, 2003). Husserl's transcendental Descriptive Phenomenology (DP) focused on enquiry into the epistemological nature of phenomena. Concepts of *lifeworld* and *lived-experience* as descriptions of phenomena were presented as free of preconceptions. Through this method, Husserl sought to uncover, evaluate and make sense of the ultimate structures of consciousness (Dreyfus and Dreyfus, 1986).

Central to DP are the concepts of *intentionality* and *essences*. Intentionality refers to getting things back to themselves through the conscious directedness of the mind towards objects (Crotty, 1997). This assumes a certainty of our own conscious awareness towards objects. Husserl considered *essences* to be the ultimate structure of consciousness (Koch, 1995). DP focuses on returning "things to themselves" through describing the essences of consciousness, grasping the essential rather than the factual which, Husserl believed, is given in immediate experience (Smith, 1978).

It has been argued that distinguishing between *fact* and *essence* does not

address the ontological difference between *real* and *unreal* (Annells, 1996). Heidegger (1962) readdressed the focus on *Being* itself and in doing so, separated his ontology from the traditional search for essences, fact or truth based on consciousness, as with Husserl (Spiegelberg, 1971).

Husserl contended that immediate experience can be grasped by phenomenological reduction or bracketing. Bracketing preconceptions involves detaching the phenomena of our everyday experience from natural living, while preserving it as purely and fully as possible (Mackey, 2003); a process which Crotty (1997) conceives as purification. The notion of pure consciousness is encompassed within Husserl's DP.

Eliminating preconceived notions of both the outer world and individual consciousness (Schutz, 1970) may be considered a form of objectivism, assuming the Cartesian dualism of a mind body split. Husserl himself contends that bracketing is achieved by modifying Descartes' method (Husserl, 2013). Indeed, DP has been considered to be the climax of the Cartesian tradition in the study of phenomena as they appear through the consciousness (Koch, 1995). Husserl conceptualized people as detached objects existing in a world of objects (Dreyfus and Dreyfus, 1986). Hallett (1995) considers it a means towards the acquisition of a final and absolute human experience. Arguably, phenomenology in this form can be considered positivism. Nevertheless, some authors claim DP focusses on subjectivity (Zerwekh, 1992; Dobbie, 1991; Elfert, Anderson and Lai, 1991; Wolf, 1991). Hallett recognises a dual or paradoxical focus on both subjectivity and objectivity, referring to it as the "most positivist research method available to nurses" (1995, p.56). In contrast to this, Heidegger does not seek a foundation or

absolute truth. He looks for an existential perspective that considers the understanding of the person's world to be essential for understanding the person.

3.4 Heideggerian Phenomenology

Heideggerian phenomenology is a philosophical discipline which focuses on consciousness and essences of phenomena towards elaborating existential and hermeneutic (interpretive) dimensions (Finlay, 2009). Hermeneutics itself is described as the theory of interpretation (Forster, 2007). Whilst Husserl refers to letting things show themselves as they are in themselves, Heidegger focused on the way in which people relate to things and found it was not as subjects relate to objects (Annells, 1996) and that awareness and consciousness did not play a role (Dreyfus and Dreyfus, 1986).

Through questioning Husserl's ideas of DP, Heidegger developed IP by extending hermeneutics beyond the description of a phenomena. He focused on understanding meanings embedded in everyday occurrences (Reiners, 2012). The objective of DP is to describe things as they appear to the consciousness (Moran, 2000) consciousness being the medium between people and the world (Giorgi, 2005). DP disregards context, focusing on experience alone (McConnell-Henry, Francis and Chapman, 2009). This pure focus on consciousness differentiates DP from IP.

The key concepts of Heideggerian IP are *time* and *space* (Tuohy *et al.*, 2013). It is within the context of these concepts that interpretive understanding takes place. This philosophical standpoint is fundamental to achieving the depth of

understanding of the phenomena of the experience of managing risk and safety for ANPs, which cannot be fully understood without acknowledging contextual factors.

Heidegger's phenomenology arose out of the rejection of the Cartesian subject-object association considered to be a characteristic of Husserl's phenomenology (Annells, 1996; Dreyfus and Dreyfus, 1986). Indeed, Heidegger challenged the traditional western Cartesian principles of dualism. He did not believe in the double existence of truth in the form of body and soul (McConnell-Henry, Francis and Chapman, 2009). Indeed, Groenewald (2004) identifies phenomenology as a suitable explorative research design, but believes it is only possible to restrict rather than prevent researcher bias. Heidegger's move away from DP was a rejection of the idea of suspending personal opinions based on the premise that reduction is impossible. This led to a move towards acceptance of endless interpretations of a phenomenon. Indeed, Heidegger (1962, p.119-192/150) states:

> Whenever something is interpreted as something, the interpretation will be founded essentially upon having fore-having, fore-sight, and fore-conception. An interpretation is never a pre-suppositionless apprehending of something presented to us.

Thus, fundamental to Heideggerian IP is the essential awareness of this *fore-sight* and positional perspective of interpretation. Indeed, Wilberg (2006) discusses how Heideggerian phenomenology focuses on the principle of awareness as the single route to all forms of reality and how it is the sole possible theory of everything. The following sections explore the key concepts aligned to Heidegger.

3.4.1 *Dasein*

Heidegger built the foundation of his work upon an ontological analysis of *Dasein* (human existence). Heidegger's analysis of *Being* is achieved by the study of everyday human existence and what it means to be a human being.

Heidegger (1962) emphasises that the *Being* of *Dasein* is its' understanding of its own *Being* (Strathern, 2002). Rose (1995) asserts that Heidegger's use of *Being* is as not a separate perceiver of a world consisting of objects outside and beyond one's self, instead it is about being part of the world. All things are understood and interpreted through *Dasein*. This research aims to achieve an understanding of *Being in-the-world* of ANPs and how managing risk is experienced and interpreted. An illumination of the *lifeworlds* of individual ANP'S will seek to uncover this phenomenon of everyday practice.

Heidegger believes that the task of ontology is to "explain 'Being' itself and to make the 'Being' of entities stand out in full relief" (Heidegger, 1962 p. 49/27). "Dasein is an entity for which, in its 'Being', that being itself is an issue" (Heidegger 1962, p.191/150). *Dasein* stands forth, creating its own way of *Being*, in a way no other entity does (Inwood, 1997). This does not mean, however, that a *Being* can choose what *Being* he is. Heidegger himself states "Existentiality is essentially determined by facticity" (Heidegger, 1962 p.236/192). Indeed, circumstances place restrictions on what one can and cannot do (Inwood, 1997).

The word *Dasein* is the combination of two Germain words *da* and *sein* which mean *there* and *be* (Dreyfus and Dreyfus, 1986); thus, *Being* there as part of the

world. *Sein*, or *Being*, is presence in the world – the upper-case 'B' denoting the ontological nature of existence (Taylor, 1995). *Being-there* as *Dasein* suggests the people (beings) understand this presence (Cohen and Omery, 1994). Thus, Heidegger uses *Being* to mean *Being-there* and being a part of the world.

Heidegger (1962, p.92/64) referred to *Being-in-the-world* as a way in which "Dasein's character is defined existentially". This is intrinsic to the entity of *Dasein*. Indeed, Heidegger's understanding of *Dasein* is a view in which we are already embedded in a world of meaning (Van Manen and Adams, 2010). Thus *Being-in-the-world* refers to being human and experiencing a situated activity in which things are encountered and managed (Reed and Ground, 1997). The assertion of *Dasein* as already *being-in-the-world* is evidence of Heidegger's rejection of the dichotomy of subject and object. It is Heidegger's argument that *Dasein* is not a *subject* (Inwood, 1997) and cannot be separated from the world. He believes that a dualistic approach to understanding *Being* cannot provide an ontological foundation to the meaning of *Being*.

3.4.2 Being-in-the-world

Heidegger places *Dasein* as *Being-in-the-world*. In fact, *Being-in-the-world* is considered to be a basic state of *Dasein*. The hyphens represent the generic connectedness between the elements, recognizing they are parts of a whole (Reed and Ground, 1997). There are three structural elements to *Being-in-the-world*: *thrownness; discursiveness*; and *projectedness* (understanding).

The term *thrownness* is used to suggest the "facticity being delivered over" (Heidegger, 1962 p.174/135). This refers to a certainty that we *Beings* find ourselves thrown into a world of context without having choice and are *falling* in our attempts to cope in the world. Heidegger (1962) contends that within this *thrownness* we are always *disposed* in a particular mood which then, in turn, influences our interpretations of meanings of our everyday existence. As Blattner (2006) explains, in our being we are "tuned into the way things matter, our tuning, our temper is our mood". This relates not only to how the world we live in has an impact on us but also how we, as human beings, encounter our world by always being attuned to it and making sense of what matters to us. Indeed, Heidegger believes that moods such as angst or boredom are a vital source of insight for the phenomenological philosopher (Inwood, 1997).

Discursiveness refers to activities and the world is articulated through language by following the guidelines of interpretation (Guignon, 1993). Discoursing, or talking, is the way in which we articulate significantly the intelligibility of *Being-In-the-world* (Heidegger, 1962 p.203/160). Whereas *projectedness* refers to our act of understanding, or making sense, by reaching ahead into the meaning of something in order to comprehend it. Heidegger (1962 p.190/150) states that:

> ...when something within-the-world is encountered as such, the thing in question already has an involvement which is disclosed in our understanding of the world, and this involvement is one which gets laid out by the interpretation.

According to Dreyfus (1991), acknowledgement of this *involvement* that is unique to Heidegger's philosophy in comparison to previous philosophers, and enables understanding to become interpretation. Indeed, Heidegger (1962, p.189/148) refers to "working-out of possibilities projected in understanding". In accordance with the trend of these preparatory analyses of everyday Dasein, the phenomenon of interpretation in understanding the world is pursued. Thus, asserting that acknowledgment of Dasein's understanding of already being-in-the-world predisposes Dasein to possibilities of interpretation of phenomena. Heidegger refers to interpretation as a "development of understanding" (Heidegger 1962, p.188/148); thus, interpretation is an advancement of understanding.

3.4.3 *Being-with* and the *They*

Heidegger explains that "*Being-in-the world*, is always one that I share with *Others"* (Heidegger 1962, p.155/119). Indeed, *Dasein's* world is essentially a public world, accessible to others as well as itself (Inwood, 1997). Heidegger refers to "being lost in the publicness of the they" (Heidegger, 1962 p.175/136). *Dasein* has already fallen away from its authentic self into the world, absorbed in being-with-one-another guided by idle talk, curiosity and ambiguity (Heidegger 1962, p.175/136).

As long as it exists, *Dasein* is *with others* (Inwood, 1997). Even *Dasein's being alone* is *Being-with* in-the-world (Heidegger, 1962). This is explained by Heidegger that *Being-with* is an existential characteristic of Dasein even when factually, no *Other* is present-at hand or perceived" (Heidegger, 1962 p.156/120). Furthermore, the *self* of everyday Dasein is the *they-self,* which we distinguish from the *authentic self* (Heidegger, 1962 p.129/96). Thus, *Dasein* is inauthentic in so far that it does

things simply because that is what *one* does (Inwood, 1997). Inauthenticity is the normal condition by which most people live most of the time. Heidegger referred to this inauthenticity and *fallenness* as *average everydayness*.

The attention that Heidegger gives to the impact and importance of authentic understanding and interpretation of the word in terms of its context of the world and *Being-with* and *Others* is an alternative standpoint of other phenomenologists who endeavour to seek a true interpretation of phenomena. So, whilst *Being-with Others* gives rise to the natural state of *inauthenticity*, Heidegger identifies a caveat:

> On the other hand, when they devote themselves to the same affair in common, their doing so is determined by the manner in which their Dasein, each in its own way, has been taken hold of. They thus become authentically bound together, and this makes possible the right kind of objectivity, which frees the Other in his freedom for himself. (1962 p.159/122)

This potentially questions the authenticity of data from qualitative interviews in which the participant and researcher *Being-with* each other is central. However, the above quote implies that the dynamics of a shared focus can achieve a liberation from the everyday state of inauthenticity.

3.4.4 Present, Ready and Unready-to-hand

Heidegger explores the world in terms of the entities or substances within it, the way *Dasein* relates to them, defines them, and makes them intelligible to their way of *Being* (Heidegger, 1962). These ways of being include: *present-at-hand; ready-to-hand*; and *unready-to-hand*. *Present-at-hand* is everything that is independent of our lives (Blattner, 2006) for example, the trees or the sun. *Ready-to-hand* alludes

to how Dasein refers to the objects that are instrumental for practical needs as an unconsciously present reality. Heidegger states:

> The less we just stare at the hammer-thing, and the more we seize hold of it and use it, the more primordial does our relationship to it become, and the more unveiledly is it encountered as that which it is – as equipment. (1962 p.98/69)

Unready-to-hand is described as the "unavailability of some-thing for use in human practice" (Blattner, 2006). When *unready-to-hand* refers to equipment, there is breakdown or malfunction and we are forced to concentrate on it, it does not solely pertain to something that is missing or unusable but also relates to that which concerns us greatly and requires our attention (Heidegger 1962). Thus, while the hammer works, we do not notice it, but when it breaks, we are acutely aware of the *unready-to-handness* of it. Thus, Heidegger's understanding of how objects and phenomena encounter the world is according to a varied conscious awareness which is situated in the context of a person's *Being* and *Time*.

3.4.5 *Time*

Dasein's Being finds its meaning in *temporality* (Heidegger 1962). Indeed, a key assertion is: "we shall point to temporality as the meaning of the being of that entity which we call Dasein" (Heidegger, 1962 p. 38/17). Heidegger argued the importance of asking the long-forgotten question of "What is being?". He believed the ontological constitution of the totality of *Dasein* is grounded in *temporality* for example, the inevitability of death. Thus, Heidegger (1962) contended that understanding is the realization of *Dasein*, which is *being-in-the-world*, concluding

that *Being* is, in itself, is *time* (Gadamer, 1982). As Heidegger puts it, "the central problematic of all ontology is rooted in the phenomenon of time" (1962 p.39/19).

If *Dasein*-derived *worldhood* significance starts with the entry of *Dasein* into the world, this can then be considered to be when time itself begins. In addition to this, if, as Heidegger states, *Dasein* is already ahead of itself, then both these assertions imply the linearity of time (Inwood, 1997). However, this is not the case. Whilst rejecting this view of linearity of time, Heidegger (1962) emphasized the importance of the *temporal* aspect of Being when attempting to give meaning to the modes and characteristics of *Being.*

Dasein's temporality is not confined in its awareness to the present moment, "it runs ahead into the future and reaches back into the past" (Inwood, 1997). Therefore, understanding entities can only be undertaken in terms of their relation to time of which there are three different modes: the past; present; and future (Heidegger 1962). Each of these three dimensions are dynamically and actively related to each other.

Another key assertion regarding time is that "time must be brought to light and genuinely conceived as the horizon for all understanding of Being and for any other way of interpreting it" (Heidegger, 1962 p.39/19). Thus, for Heidegger, *temporality* not only unifies past, present and future but is also the structure of *Dasein's* purposeful acts, i.e. it is the "fore structure of understanding that grounds all our interpretations" (Plager, 1994). Thus, rather than bracketing, Heidegger believes that the way we have been and what we have already experienced makes possible an interpretation of what we are presently experiencing or attempting to understand (Rose, 1995). Furthermore, Inwood (1997) asserts that *Dasein's* finite

temporality is advantageous. Unlike an infinite, supra-temporal unchanging deity, *Dasein* is open to and opens up to the world. Heidegger (1962, p.399/348) refers to the present as "always offering something 'new', it does not let *Dasein* come back to itself and is constantly tranquilizing it anew". Thus, for Heidegger, a true interpretation of a phenomena is in itself temporal and restricted to a specific time from a perspective of *Dasein*.

3.5 From Understanding to Interpretation

Knowledge is referred to by epistemologists as a truth, which is defined as the accurate representation of an independently existing reality (Smith and Hodkinson, 2005). Conversely as a Phenomenologist, Heidegger speaks of *understanding* as a *projection* of *Dasein* on its possibilities: "in that Dasein has understood itself and will always understand itself in terms of possibilities" (1962 p.145/110).

Heidegger's purpose in asking the question of *Being* was an attempt to comprehend our understanding of our practices, by presenting thematically what human beings obliviously do all the time (Dreyfus, 1991). Thus, through Heideggerian philosophy, the aim of the research was to seek to understanding of the *everydayness Dasein* of ANPs and their *Being-in-the-world* of managing risk. While everyday *Dasein* has a preconceptual understanding (Inwood, 1997), this research seeks to give a conceptual account of the ANP experience of risk moving from understanding towards interpretation.

A fundamental feature of *Dasein's* experience is our familiarity with the world that we live in and how the background to this is concealed from us. As Heidegger explains "the entities encountered environmentally as closest to us

remain concealed" (1962, p.131/98). This concealment is grounded in the fact that we take for granted and become absorbed in everyday life and it is this concealment that is central to Heidegger's philosophy. And yet, according to Dreyfus (1991), this has not been directly addressed by philosophical tradition for over two thousand years. Thus, Heideggerian thought reasserted this focus onto ontological understanding and away from epistemology.

According to Heidegger, a phenomenon can be uncovered *ontically* (our everyday being) and/or *ontologically* (deep structures of being). The deep structures of being (the ontological) are rarely noticed or examined, yet they explain and underlie the everyday being (the ontic) (Frede, 1993). *Dasein* is *ontically* "closest to itself and ontologically farthest; but pre-ontologically it is surely not a stranger" (Heidegger, 1962 p.37/16). This refers to the fact that one's proximity of existence in the world leads to a lack of conscious awareness and a difficulty in defining our own state of being. Arguably, it is through undertaking fundamental ontology such as phenomenology that the question of *Being* can be uniquely answered by bringing to light the things that meaningfully appear or are significant to us. As Heidegger (1962, p.171/133) states: "To say that is it 'illuminated' means that *as* Being-in-the-world it is cleared in itself, not through any other entity, but in such a way that it is itself, the clearing".

Thus, for an entity which is cleared in this way, that which is *present-at-hand* then becomes *accessible in the light*. Dreyfus (1991) uses the analogy of cutting down trees in a forest to create a clearing or shared understanding of that phenomenon. Heidegger (1962, p.237/192) states that "Being in the world is essentially care". A phenomenon is illuminated through care or concern of the

endeavour. Indeed, as explained by Inwood (1997), *Dasein* is rooted in a basic state of *care*, the two senses being *caring* or *having concern* about something, and secondly, *taking care* of things. However, Heidegger (1962, p.239/195) deconstructs this concept of *care* further stating that the "average everydayness of concern becomes blind to its possibilities and tranquilizes itself with that which is merely 'actual'". It is through Heideggerian philosophy that an awareness of this will enable a clearing and illuminate ANPs' *Being-in-the-world* of managing risk in order to achieve this illumination of *understanding.*

Although interpretation does not focus on the environment as a whole, it presupposes an understanding of it in so much that "when something within-the-world is encountered, the thing in question already has an involvement which is disclosed in our understanding of the world, and this is one which gets laid out by the interpretation" (Heidegger, 1962 p.190/149). Heidegger (1962) then goes on to explain that even if it has undergone an "interpretation", it then recedes into an *understanding* when it does not stand out from the background. This seems to suggest a hierarchy of insight and focus according to meaningful significance as per *Dasein's* perspective.

According to Heidegger, all interpretation, from the everyday to the philosophical, involves *a fore-having*, a *fore-sight* and a *fore-conception*. *Fore-having*, according to Heidegger (1962) is where, in every case, the interpretation is based on "something we have in advance" (Heidegger, 1962 p.191/150), the background context in "which Dasein knows its way about... in its public environment" (Heidegger, 1962 p.405/354). *Fore-sight* refers to the fact that we always enter a situation or experience with a particular view or perspective. *Fore-*

conception is the anticipated sense of the interpretation which becomes conceptualised. In the case of this research, the *Dasein* of both the participant and researcher each have a preliminary/notional understanding of their *Being* before attempting to make sense of, and ultimately interpreting, the phenomena in question.

If it is inherent that *Beings* are uncovered or illuminated by *Dasein* imperfectly through a tendency to misinterpret itself and other beings, then a philosopher who is also a *Dasein* is prone to the same misinterpretations (Inwood, 1997). Furthermore, if *Dasein* is the primary locus of truth (Frede, 1993), then seeking is a process of un-concealment or uncovering things; "illumination is never complete, nor ever wholly absent" (Heidegger 1962, p.95/67). It is Heidegger's (1962) contention that understanding or non-understanding can only take place through *Dasein's* intelligibility which is structured via the *Hermeneutic Circle*.

3.6 The *Hermeneutic Circle*

The process of Heideggerian hermeneutics as a method of inquiry adheres to the principle of the *Hermeneutic Circle*. For Heidegger, all forms of human enquiry are circular (Spanos, 1976), emphasizing the nature of *Being* and, indeed, *Being* as a never-ending circular process. The *Hermeneutic Circle* is an expression of the existential *fore-structure* of *Dasein* itself and ultimately an expression of *understanding*.

Heidegger's *Hermeneutic Circle* takes into account preconceptions of something's *Being* before approaching it to understand and interpret it. This is the key difference with DP. Heidegger believes entering that circle with an awareness

of preconceptions has the potential for enlightened understanding rather than simply a vicious circle of endless interpretations. All understanding is an interpretation from a perspective, even the natural scientific method is interpreted knowledge (Heidegger 1962). The *Being* of something cannot be separated from the world. Rather than Husserl's bracketing, Heidegger argued for an awareness of how the world of the observer can influence his or her understanding of the true nature of the object of study (Heidegger 1962).

Heidegger emphasized the importance of "working out of these fore-structures in terms of the things themselves" (1962 p.195/153) so that rigorous interpretation can be possible. He explains the *Hermeneutic Circle* as one example of existential interpretation with regard to presuppositions from which further propositions are deduced about the *Being* of *Dasein* according to the formal rules of consistency. Heidegger (1962) believed that it is within the circle that there is a hidden, a positive possibility of the most primordial kind of *knowing*.

Heidegger (1962) himself refers to a circular argument, stating that circular proof in the existential analytic cannot be avoided because this analytic is not proved through logical consistent rules. "It is not to get out of the circle of understanding but to come into it in the right way" which is essential (Heidegger, 1962 p.195/153). The interpretive process is therefore always reflexive and never ending. Heidegger has been criticized for a perceived attempt to immunize his conception from criticism by "deliberately sheltering it under a mantle of apriorism" (Albert, 1994). This poses the question of whether there is knowledge without experience, which can lead to an argument that is circular in itself with no finite truth. Heidegger (1962 p.363/315) advises: "we must endeavour to leap into

the 'circle', primordially and wholly, so that even at the start of the analysis of Dasein we make sure we have a full view of Dasein's 'circular Being." Heidegger (1962 p.194/153) warns "If we see this circle as a vicious one and look out for ways of avoiding it, even if we just 'sense' it as inevitable imperfection, then the act of misunderstanding has been misunderstood from the ground up." One remains in the circle through recollection and repetition; these are both grounded in *interest*, *care* and *concern*. In the case of this study, as the researcher, I made the metaphorical leap into the circle and, through a phenomenological hermeneutic lens, attempted to view the circular being of the *Dasein* of each participant, to interpret their lived experience of managing risk and patient safety.

3.7 Heideggerian Phenomenology as a Research Method

As a major qualitative tradition (Creswell, 1989), phenomenology has been conceptualized as a philosophy, a research method, and an overarching perspective from which all qualitative research is sourced (Maykut, Maykut and Morehouse, 1994). Phenomenology is described as an approach, rather than a method, of undertaking research (Dahlberg *et al.*, 2008). Thus, rather than procedural, it indicates an expectation of individual interpretation and variation. It is an approach that is now widely acknowledged and applied in the social sciences (Fendt *et al.*, 2014), Heidegger himself did not provide a research method and thus created a challenge for researchers (Ashworth, 1997). In fact, there is a perception of reluctance coming from phenomenological researchers regarding using a structured approach (Earle, 2010; Norlyk and Harder, 2010; Caelli, 2001; Annells, 1996). Rather than dictating a step-by-step research process, it is argued that what

Heidegger does provide for researchers is a way of thinking about the world (Jack and Wibberley, 2014). Indeed, Smythe *et al.* (2008 p.82) argue that research is a thinking "that which is pointed to as something to be thought about".

Phenomenological research is seen as complex due to the esoteric and daunting nature of the language used (McConnell-Henry, Francis and Chapman, 2009; Pereira, Kleinman and Pearson, 2003). Furthermore, contentious issues of phenomenology, such as its lack of structure, being elusive, elite, or boutique (Lawler, 1998) have led to questions and criticisms regarding rigor (Wimpenny and Gass, 2001). Indeed, in order to apply the approach effectively, "nurse researchers using phenomenology as a methodology need to understand the philosophy of phenomenology to produce a research design that is philosophically congruent" (Converse, 2012 p.44). Heideggerian phenomenology presents many conceptual, theoretical and applied challenges to researchers (Fendt *et al.*, 2014). Effective use of this approach requires time, personal involvement, deep immersion to come to terms with, at times, impenetrable language and perplexing concepts, especially during interpretation, as this is not a well-defined process (Miles, Huberman and Saldana, 2013; Converse, 2012).

The researchers *fore-structure* is the fundamental perspective from which an interpretive understanding of a phenomenon is achieved (McConnell-Henry, Francis and Chapman, 2009). The researcher is "as-thinker", and so too is the reader who is called to think about "this" and not so much about "that" (Smythe *et al.*, 2008). Gadamer (1982) comments that "all is in-play", "being played" and sometimes "out-played" refer to the inclusive nature of all aspects, perspectives

and information available for consideration in interpretation. IP bridges subjective and objective knowing by focusing on individual perceptions of phenomena and uncovering common themes and universals that emerge from the narratives of persons' lived experiences (Tarzian, 2000).

Phenomenology's association within nursing and social sciences is well recognized (Friesen, Henriksson and Saevi, 2012; Eatough and Smith, 2010; Garza, 2007; Todres, 2007; King, 2006; Churchill, 2002; Diekelmann and Ironside, 2002; Caelli, 2001; Rae, 2000; Carswell and Rae, 2000; Koch, 1999, 1995; Van Manen, 1997; Taylor, 1995; Walters, 1995; Benner, 1994, 1985, 1994; Benner and Wrubel, 1989; Omery, 1983). The question to be asked is: Why do nurses align with phenomenology? Indeed, it has been described as the "perfect fit" for nursing research by some (Miles, Huberman and Saldana, 2013) and, similarly, has been considered profitable for nurses endeavouring to understand the human experience (Corney, 2008). It has also been argued that phenomenology enables nurses to comfort and treat patients more effectively (Sandelowski and Barroso, 2009). Converse (2012) contends that phenomenology provides in-depth insights for nurse researchers, ultimately facilitating patient care that is more meaningful. Conceivably, a methodology that guides one to understand and interpret the phenomena of managing risk and safety enhances understanding of the experience and is beneficial to educators, ANPs, and ultimately patients.

Arguably, interpretation rather than pure description is key to understanding. As such, Smith (1978) cautions that described or observed data do not speak for themselves. Furthermore, Heideggerian IP positions *Dasein* (existence) as already

in-the-world meaning it cannot be separated. The context in which ANPs operate in managing risk and patient safety is key to its understanding. This is the contextual focus that justifies the alignment of this study with an interpretive approach.

3.8 My Theoretical Perspective

My philosophy and central theoretical perspectives are aligned to the work of Heidegger and IP. It is the shift of phenomenological research from description to interpretation, from epistemology to ontology, from knowing-that to knowing-how (Conroy, 2003) that resonates with my worldview. Rather than seeking an objective numerical universality of a quantitative understanding, or a purely descriptive understanding, I believe in the value of a shared interpretation of the lived experience of a phenomena within the context from which it is experienced.

To simply declare my alignment with the worldviews of Heidegger is insufficient without context. As a researcher, a nurse, an ANP and as a wife and a mother, I live in a world of *others.* It is not that that each person has his own world as is Husserl's interpretation, neither that one has an *inner sense* as Kant asserts. Dreyfus, Dreyfus and Zadeh (1987) explain that in Heideggerian philosophy it is not only *your* world but also the world of *others*. We are all embroiled in coping with the *everyday* which gives us each our perspective on the world. Therefore, the '*I*' discloses the same world that *others* each disclose. Within the *clearing* or space created by a Heideggerian approach to research, there is a *lighting up* and a shared understanding. I am aligned with Heidegger's belief that *Dasein* as a *Being* is always open to a world of a shared *understanding*. In shaping this *understanding*, *Dasein* draws on things outside of themselves to make a stand on their own *Being*.

Heideggerian philosophy promotes the raising of questions around the taken-for-granted practices of everyday life. Thus, once the Heideggerian, hermeneutic phenomenological researcher has described in detail the lived experience or phenomenon, the researcher can then reflect back on the interpretative findings and uncover the conditions of possibility for future practice (Heidegger, 1962).

From a perspective that is influenced by the theoretical and practical knowledge of managing risk and safety as both a nurse and an ANP, I entered into the *Hermeneutic Circle* with the quest of uncovering this area of practice for the benefit of patients, public, policy writers and for ANPs themselves.

According to Heidegger (1962), once understanding has a basis it can be projected, shared, and often resonates with others. Indeed, "understanding always relates to the future" (Palmer, 1969). It enabled uncovering an understanding to move beyond understanding towards an interpretation of how ANPs experience managing risk and patient safety. Furthermore, it allows for a new way of thinking about future practice. Dreyfus (1991) confirms that Heidegger's thinking has enabled not only philosophers, but also researchers, to recognize alternative ways of understanding and acting that have been neglected in the past.

Whilst I am aligned to this interpretive phenomenology world-view, I do not reject all positivist methods as a form of enquiry in all areas of the research process. This is evident in the literature review and in the methods in which I have incorporated positivist strategies such as the CASP critical appraisal and utilised terms of bias, generalisability and sampling. As stated previously (see 1.4 and 2.8), it is my belief that it is not an imperative that quantitative and qualitative methods and strategies should be used in entire exclusion of each other. On the contrary, these

traditionally opposing approaches, can be and should be used together in a complementary fashion, if deemed suitable (Tashakkori and Teddlie, 2003).

Having explored the choice of Heideggerian IP as the guiding philosophical lens through which to approach this research, the following chapter discusses the application of this philosophy to the methodological design of this study.

Chapter Four – Methodology

4.1 Introduction

The previous chapter outlined the underpinning philosophy of Heideggerian IP. In this chapter it is demonstrated how this philosophy translates into a methodology and its application for this research.

4.2 The Heideggerian Approach

The approach to this qualitative research is informed by Heideggerian IP, as outlined in Chapter Three, with the aim of exploring the lived experience of ANP's managing risk and patient safety in acute settings.

Much literature cites Heideggerian phenomenology as being challenging to understand (Cerbone, 2009; Dreyfus and Wrathall, 2007; Sheehan, 1998). Translation of central Heideggerian concepts to research methodology is well debated (Paley, 2005, 1998; Crotty, 1997; Holmes, 1996). However, it was considered that for the purposes of this research, this underpinning philosophy offered an appropriate lens through which this phenomenon was illuminated. The difficulty in understanding Heidegger is perhaps more in terms of achieving a consensus of understanding, which surely cannot be achieved if the fundamental premise is individual interpretation. The essence of Heideggerian philosophy is that it is individually interpreted, and my interpretation of the philosophy is explicated through my application. Indeed, it is Heidegger's focus on interpretation that is key to succeeding the research aim, in revealing and expressing the human experience of this phenomenon.

The limited literature on the application of Heideggerian IP to the research process (Horrigan-Kelly, Millar and Dowling, 2016), fuels the argument that Heidegger's philosophy was not developed as a research method (Paley, 2005, 1998; Crotty, 1997; Holmes, 1996). However, Heideggerian IP has influenced and been utilised in multiple previous research projects (Friesen, Henriksson and Saevi, 2012; McConnell-Henry, Francis and Chapman, 2009; Garza, 2007; Todres, 2007; Diekelmann and Ironside, 2006; Churchill, 2002; Taylor, 1995; Walters, 1995; Omery, 1983).

There have been criticisms of not using Heideggerian philosophy directly (Horrocks, Anderson and Salisbury, 2002; Cash, 1995) Notably, Crotty (1997) criticized Benner (1984) for utilizing a Dreyfus interpretation of Heidegger rather than using the Heideggerian philosophy itself. Heidegger's philosophy, when directly applied, can be a powerful tool in phenomenological research (Horrigan-Kelly, Millar and Dowling, 2016) as it facilitates a clarification and understanding of the human lived experience (Friesen, Henriksson and Saevi, 2012; Eatough and Smith, 2010; Caelli, 2001; Carswell and Rae, 2000; Rae, 2000; Koch, 1999; Van Manen, 1997; Koch, 1995; Benner, Tanner and Chesla, 1992; Omery, 1983). It is the intention of this research to use Heideggerian phenomenology in its original sense to facilitate an interpretive understanding of the phenomenon of the management of risk and safety by ANPs.

Direct use of Heideggerian philosophy, combined with shared interpretation of individual lived experiences of a phenomenon, may be considered to achieve understanding isolated to individuals. However, it is the multiple data sources that enhances trustworthiness and credibility (Lincoln and Guba, 1985). According to

Creswell (1998), the "backbone" of qualitative research is extensive collection of data from multiple sources of information. The multiple sources in this case are not only the ten participants, two interviews, and two written reflections, but, in line with IP, it is also the researcher's own experience, journal, and dual interpretations of both participant and interviewee. Breitmayer, Ayres and Knafl, (1991) argue that triangulation through multiple data enhances trustworthiness by adding to the jigsaw puzzle of knowledge. The differing modes of data collection aim to facilitate an assembling of pieces of raw data from the various sources to create a multidimensional picture of the phenomenon. In Heideggerian terms, these forms of data collection are an enablement to shine a light or create a *clearing* in which something can show itself or be *unconcealed*.

4.3 Participant Sampling

In order to identify appropriate participants to inform the research question, purposive sampling was used involving a selection of individuals with relevant experiences to the aims of the study and in the locations where the phenomenon of inquiry is found (Denzin and Lincoln, 2000). The three locations were an ED, MIU and an UCC as the aim was to capture the phenomenon being used in a range of typical acute settings where ANPs work (RCN, 2018).

Purposeful sampling, commonly used in phenomenology to acquire rich thick descriptions of phenomena was utilized (Bedwell, McGowan and Lavender, 2012; Converse, 2012; Hollywood and Hollywood, 2011; Sabo, 2011; Priest, 2002). This sampling identified willing participants, who were experienced with the phenomenon of interest (Creswell and Clark, 2011), and were able to articulate

experiences in an expressive and reflective manner . The aim was to achieve an information-rich depth of understanding of the phenomenon in question (Patton, 2002).

Inclusion and exclusion criteria targeted appropriate participants for the data required. Key criteria were: qualified ANPs with a BSc or MSc in Advanced Practice or Emergency Nurse Practice, two year minimum experience post-qualification and working in an acute setting. Exclusion criteria: non-nurses, unqualified ENPs, less than two years' experience and those who did not identify with managing risk. The limitations of homogenous participant groups having potential for lack of generalizability and bias and are well documented (Palinkas *et al.*, 2015). Less experienced ANPs or other professionals may have achieved interesting data, however, in seeking rich understanding of this little-known phenomenon, these criteria were considered essential.

The inclusion criteria of a minimum of two years post qualification ensured sufficient experience for the participants of managing risk and safety. This experience afforded a level of insight beyond description, towards a deep, shared interpretation of the lived experience. In view of evolving ANP definitions as outlined in Chapter Two, it was important to achieve consistency of sampling of the ANPs included in the study. As discussed in 2.3, there is a current discrepancy and some confusion within title, role preparation and scope of ANPs. It is noted that whilst Master's level education will be a future standard for ANPs, it is not the current situation for experienced ANPs practicing today (King, Tod and Sanders, 2017). Subsequently, to achieve a true representation of experienced ANPs, it was decided that having a Masters qualification was not a necessary inclusion criteria

for this study. A decision was made to include ANPs with an ENP diploma qualification rather than exclude them on the basis of the absence of a Master's qualification. This decision is justified on the basis of seeking to achieve a sample with sufficient experience to acquire rich data. This is in recognition that a significant proportion of experienced ANPs practicing today do not hold Master's qualification. Indeed, it should be noted, Heideggerian IP seeks an interpretive understanding from the perspective of the lived experience.

Between two and ten participants are considered sufficient for saturation in phenomenological inquiries (Giorgi, 2003; Boyd, 2001). Saturation is the point at which sufficient data has been acquired such that further data collection and/or analysis is not necessary (Saunders *et al.*, 2017). Some argue that rich personal accounts are the goal of phenomenological enquiry rather than saturation (Manen, Higgins and Riet, 2016; Hale, Treharne and Kitas, 2007). Guetterman (2015) examined sampling practices across eleven health-related phenomenological studies identifying the mean sample size as twenty-five (minimum of eight). Adequate qualitative sample sizing is ultimately a matter of judgement and experience (Sandelowski, 1995). It was decided that eight participants were sufficient for this research, as small samples potentially lead to rich, in-depth narratives (Kosowski and Roberts, 2003). This decision was also based on the capacity of the researcher, particularly with multiple data management.

To protect against potential participant drop-out, ten ANPs were recruited. All ten participants (five male, five female) stayed with the research process throughout. It was the researcher's endeavour to establish and maintain rapport utilising good communication throughout data collection, as such activities have

been attributed to minimizing the potential risk of participant drop-out (Finlay, 2009).

The challenge of limited literature on purposive sampling guidance (Norlyk and Harder, 2010) was overcome through investigating and incorporating elements from similar research where purposeful sampling had been used (Bedwell, McGowan and Lavender 2012; Converse, 2012; Hollywood and Hollywood, 2011; Sabo, 2011; Priest, 2002). An example of this is Bedwell, McGowan and Lavender's (2012) study of midwives' experiences of intrapartum care in which an initial letter of invitation was sent to midwives in three hospital trusts, followed by an email and face-to-face meetings which informed the process for sampling in this study.

For this study, letters sent to the head of nursing in each of the three sites (Appendix 5) were then forwarded to potential recruits. Ten participants responded, and voluntary participation was secured from all respondents. Further email communication clarified the research and was followed up with a telephone conversation ensuring the participants were fully informed and to confirm that the participants met the criteria. Email communication to plan a time and place for the first interview followed.

4.4 Accessing Sites

The decision to access a minimum of three sites was made on the basis that multiple sites offered insurance against participant drop-out or restricted access from gate-keepers of sites (Feldman, 2003; Gummeson, 2000; Lee and Renzetti, 1993). Whilst it is not the intention of phenomenological research, multiple sites

may achieve more generalizable results or at least a greater breath of enquiry (Shenton and Hayter, 2004; Patton, 2002).

The three sites chosen for inclusion in this study were an urban ED, a suburban UCC and a collective of rural MIU's, referred to as Sites A, B and C respectively. A fourth site, another urban ED department, was contacted as a precaution but responded with such a delay that recruitment had already started, and it was decided a fourth site would not be necessary.

ANPs work across a variety of acute settings including ED, MIUs, and UCCs (Lee, 2012; Feldman, 2003; Gummeson, 2000). These settings were chosen as they represented acute working environments across urban, suburban and rural settings and therefore potential *lifeworld's* of ANPs who are likely to work between these areas. Collecting data from three different settings may be considered triangulation to contrast and validate the data (Bloor, 2013; Arksey and Knight, 1999; Holloway, 1997). Setting diversity aimed to capture the different levels of risk according to contextual factors such as level of medical support, access to investigation, and proximity to District General Hospital. This contextualist position aligns with the Heideggerian viewpoint. As discussed in Chapter three, Heidegger asserts that one's being in the world is not objective or decontextualized and, indeed, one's understanding always arises out of a specific situation or context (Clarke, 2010). Thus, by using different sites or contexts for this research, this not only aligns with Heideggerian philosophy but also potentially enriches the interpretative understanding of the data.

Site A was a Medically Led ED located within a large teaching hospital in the centre of a City in England. The hospital has close links with two universities and

provides Acute Medicine and Surgery, Critical Care, Trauma, Orthopaedic as well as ED services to the local urban population. Site B was an UCC within a Community Hospital situated on the outskirts of a city approximately twenty-five-minutes by car to the nearest ED. This Nurse-Led Unit offered a daytime service covering a suburban and rural community for patients of all ages with minor injuries and minor illnesses. Site C was an organization that covered staff working across several rural nurse-led MIUs serving predominantly semi-rural and rural communities with minor injuries. Each unit was set in Community Hospitals located on average at least forty minutes away by car to the nearest ED.

For permission to access participants in site A to be granted, the Research and Development Department (R&D) and the Clinical Audit and Effectiveness Manager required evidence of university ethics approval and confirmation from the Integrated Research Application System (IRAS) that no further NHS approval was needed. Once permission was granted, the Lead Nurse of the ED department was emailed, and participants recruited. This email contained the letter to Head of Nursing detailing the research (Appendix 5), the Participant Information Sheet (PIS) (Appendix 6), and Consent Form (Appendix 7). The Lead Nurse then forwarded this information to potential recruits. Three male participants were recruited from this site.

Accessing participants from site B followed the same process as for site A. There was a query from Site B for further confirmation as to whether an IRAS form was required for NHS approval. Using a simple Health Research Authority (HRA) decision tool online, as directed by a Research manager at site C, this study was considered “service evaluation” rather than “clinical research” and therefore IRAS

form was not required. The Director of Studies also completed this decision tool as confirmation. I formally presented my proposed research to the organisation's Clinical Leads at a cabinet meeting. Further approval was gained from a Question, Interview and Survey (QIS) group who reviewed the interview schedule. No specific concerns were raised and permission to proceed was granted. This was the longest of the three processes. Three female participants were recruited.

Site C's access process was similar to A and B but was the most time efficient of all three. This was predominantly due to a very facilitative R&D lead who guided the process, which included an organization-specific ethics form and a comprehensive investigation of the research. Four participants, two male and two female, were recruited.

4.5 Data Collection

The purpose of this research is to understand and interpret the lived experience of ANPs managing risk and safety in clinical practice. Establishing an appropriate data collection strategy was fundamental to extracting the depth and richness of data to achieve the research aim. There were three phases of data collection. The first phase was a qualitative semi-structured interview, the second phase consisted of two written reflections, and the third phase, a second interview. There was an average of six months between interviews to allow for transcription and initial analysis.

This study may not be considered longitudinal as it may imply a time period of many years (Caruana *et al.*, 2015). However, the multiple data collection and contact points between participant and researcher over six months potentially

afforded a greater depth of enquiry and insight into changes over time than a single interview would have achieved. The punctuated time period of engagement and trust-building potentially enhanced research credibility by maximising opportunity for variation on the topic (Lincoln and Guba, 1985). This relates to Heidegger's concept of *temporality* in which each participant's lived experiences of *Being* could be interpreted contextually in relation to *time*. *Temporality* not only unifies past, present and future but is also the structure of *Dasein's purposeful acts* (Heidegger, 1962). The time period affords a likely variation of interpretation and thus aligns with Heidegger's viewpoint that there is no one absolute truth or answer to this research question, but an interpretation according to the context of *Being* and *Time*.

4.5.1 Semi-structured Interviews

Kvale (1994) believes that the best way to know how people perceive something is to talk with them. The belief that seeking a shared interpretive understanding through conversation relates to Heideggerian concepts of researcher is *being-with* the participant. This creation of a *clearing* or making a space to understand a phenomenon through *discourse,* aids achieving a shared *interpretation*. Semi-structured interviews created this space for conversation in order to understand the participant experiences of risk and patient safety (Creswell *et al.*, 2007; Lincoln and Guba, 1985). The semi-structure guided focus on the phenomenon, facilitated the participants to talk whilst also enabling me to clarify and adjust my questioning (Burkard and Burkard, 2009; Ryan, Coughlan and Cronin, 2009; Creswell *et al.*, 2007). Each interview was a dyadic interaction situated in a specific context and

time (Payne, 1999). The second interview not only facilitated clarification and deepening enquiry but also added the element of *temporality.*

The interviews served as empathetic interpretations in order to deconstruct the familiar phenomenon of managing risk and patients' safety for ANPs. The interviews aimed to understand this lived experience and its meaning to those participants (Seidman, 2006) by providing an insight into the participants' attitudes, experiences and perspectives (Ryan, Coughlan and Cronin, 2009). It is through understanding that the ontological-existential structure or impact of the researcher's *Dasein* or existence *being-along-with* the *Dasein* of the participant that is key to *understanding* and *interpretation*. Shared interpretation happens through the researcher *being-alongside* the participant facilitating *discourse* which is described as the deepest unfolding of language (Emad, 2007).

Semi-structured interviews are commonly used in phenomenological enquiry (Norlyk and Harder, 2010; Kleiman, 2004; Lopez and Willis, 2004; Holstein and Gubrium, 1995). There is a questionable assumption that interviews achieve an accurate and true picture (Fontana, 2008). However, if, as Heidegger (1962) believes, *Dasein* exists largely in *inauthenticity* and according to the expectations of *Others*, then interviews achieving true and accurate picture is contestable. Positivists criticise interview methods as a weak method of data collection, as self-reporting lacks rigor, bias-prone, and lacks generalizability (Jensen and Rodgers, 2002). Despite these criticisms, positivists use exploratory interviews as a means of inductively deriving hypotheses to be subsequently tested by more rigorous quantitative research. This leads back to the fundamental question of whether

scientific knowledge has the root in conversation and communication with contestable truths and alternative interpretations (socially constructed). `The counter argument is that it is not influenced by the observer and represents a pure reflection of reality (Kuzmanic, 2009). I am aligned with Heideggerian understanding that there is no single truth and that there are multiple interpretations of the truth according to each perspective of *Dasein*.

The interviews began with some pre-prepared, open-ended warm-up questions and further question prompts for each stage of the reflection. Whilst these questions aid the less experienced interviewer, the key tool during the interviews was active listening, as this enabled the participant-led shared journey. Kvale (2006) believes that active listening is "more important than the specific mastery of questioning techniques". Gibbs (1988) reflective cycle offered a loose structure, a simplistic reflective tool with flexibility for participant-led interviews whilst maintaining focus on the research aim (Appendix 8). The reflective story-telling accessed participants' realities (Oiler, 1982) whilst also revealing shared practices and common meanings among their experiences (Brewer and Nelms, 2000) of managing risk and safety. Storytelling is considered to effectively reach lived experience (Smyth, 2011; Dinkins, 2005; Van Manen, 1997; Benner, 1994); by telling their story, participants concentrate and reflect on specific experiences and in doing so are less likely to speak of their generalized experience (Smyth, 2011). By remaining with their own specific experiences and *Being-there* as oneself and focusing on the issue of their own *Being*, the route to the essence of the participants existence or *Dasein* is achieved.

Aligned with the beliefs of IP, researchers, rather than being passive, are an integral part of the research (Van Manen and Adams, 2010). Dinkins (2005), refers to researchers as a:

> living, breathing part of the research that engages in a dynamic developing conversation which takes shape in a mode of inquiry that is shared by the researcher and participant who are in the same space speaking, questioning, debating, challenging and ultimately searching for understanding.

Researchers in a hermeneutical inquiry aim to fully engage in the interview situation, be open to what 'is' and open to 'the play of conversation' through embracing Heidegger: "Embracing Heidegger's understanding of *Dasein* as being-there, *being-open*, being-in the-play, going with what comes, awaiting the moment of understanding" (Smythe *et al.*, 2008).

Interviewer preparation involved reading literature regarding phenomenological interviews and endeavouring to have an insightful self-awareness. This self-awareness grew out of reflexivity, which was also facilitated through immersion into the philosophy of Heidegger. Reflecting on concepts such as *Dasein*, *being-there*, *being-with*, *the other*, *discourse*, *disclosure*, and *authenticity* that afforded a deeper connection and alignment with the underpinning philosophy through the research process.

4.5.2 Phase One - First Interviews

To maximize the potential of the phenomenological interview, the core skills of interviewing were focused upon. Examples of this included establishing rapport, active listening, being non-judgmental, and open minded (Faan, 2014). These skills attuned to nursing, were further developed from previous qualitative interviewing

experience. A pilot interview aided in confidence building, gaining insight, identifying flaws, limitations and weaknesses (Kvale, 2007). This provided reassurance of the interview schedule, and effective interviewer skills enabling quality, flowing, rich data. An important learning point highlighted the reliance on equipment when the tape-recorder did not record the interview. A reflective supervision session followed, and all subsequent interviews were recorded on a reliable device.

Dynamic reflective awareness throughout the research led to insights and adaptations in approach. Reflexivity boxes can be found throughout this thesis with excerpts from a reflexive journal kept.

Initial concerns regarding lengthy interviews were positively reflected upon during supervisions, and any constraints on time-keeping were highlighted with participants. Dynamic reflexivity regarding the impact of internal and external factors that arose affecting each interview was imperative. One external factor that arose was a participant receiving a phone call during an interview, with a resultant demonstration of respect and flexibility. Examples of other factors were: concerns about possibly being overheard leading to a room change, providing a drink for a cough and changing a squeaky chair (see Figure 1 for reflexivity excerpt). Examples of internal factors were losing the thread of conversation, concerns about whether the incident was "good enough" to reflect on, or sudden feelings of exposure, such as "oh, I sound so manipulative…". Being actively aware and authentically responding as they arose was imperative to remove barriers to effective communication and to maintain rapport and trust building. A ten-page sample of one of the transcribed interviews can be found in Appendix 9.

In recognizing costs and benefits for the participants (Kvale, 2007), I ensured the interviews were convenient to participants with regard to time and location. I also ensured participants were well prepared for what to expect through prior communication, emails, and follow up telephone calls. As the interviewer, early arrival, set up, and note taking during the interviews informed immediate reflections post-interview. These, and subsequent reflections, during initial listening and transcribing, facilitated iterative critical thinking.

October 2016 Squeaky chair *"During the interview Beth declared that her squeaky chair was driving her mad. Present-at-hand – the chair (equipment) was broken thus it became the focus This was her space, her environment, her chair but my responsibility to create this shared space. Creating the space in which meaningful discourse can take place includes physical space as well as an interpersonal Being-with…"*

Figure 1: Reflexivity Box 1

4.5.3 Phase Two - Written Reflections

Having reaped a thick rich data in the first interview, the written reflections were a tool to facilitate ongoing iterative interpretation and further understanding for the participants of their lived experiences of managing risk and safety in practice. Participants were contacted during the week following the first interview with an invitation to describe two incidents in five hundred words detailing how they managed risk and patient safety in their practice and with a brief reminder as to what was required. A bespoke template was created and attached (Appendix 10). Participants were asked to return these two weeks before the second phase of

interviews. The time gap between interviews allowed for transcription, analysis, and total immersion into the primary interview.

These reflections elicited further interpretive understanding of the phenomenon and informed the second face-to-face interviews (Butler-Kisber and Poldma, 2011). Preliminary analysis and refection of the first interviews and the reflections partially fed into the structure of the second interviews allowing for further exploration and clarification. These extended reflections over a period of time facilitated an iterative process which, rather than describing, lends itself and aligns with a Heideggerian interpretive approach for a deeper level of analysis (Smith and Osborn, 2015). The written reflective templates utilised Gibbs (1988) reflective model providing a consistent approach and a simplistic tool for the participants to use to recount two further experiences in which risk and safety was managed, in narrative form. Narrative research is a relatively recent branch of interpretive research design facilitating the study of how human beings experience the world (Moen, Gudmundsdottir and Flem, 2003 Gudmundsdottir, Moen and Flem, 2001).

The value of the written reflections as a data source can lessen the impact of intrusion or alteration of setting that the presence of a researcher can have (Merriam, 2009). Thus, they promote a reflective attitude in contrast to face-to-face interviews where people are more immediately involved (Van Manen, 1990). The inclusion of the written reflections as a further form of data is an acknowledgement of the potential effect of the presence of the researcher in the interviews, as Heidegger would refer to as the *other* and may give rise to increased *inauthenticity* of the participants' *self.* The written reflections allowed participants

to select aspects pertinent to their unique insights that would inform the study aims with less interviewer impact or pressure than interviews can create. Ultimately the aim of the written reflections was to reveal the phenomenon of the management of risk and safety in its most authentic form.

In stark contrast to the emotion and care elicited during the face-to-face interviews, some participants were less impassioned in their reflections. The emotional detachment may well have been that the reflection was a mere task to be completed rather than being representative of their caring behaviours. It most likely indicated motivation to get the reflection done rather than a lack of care. In my journal, I considered whether the written reflections allowed the participant to disassociate from the experience without the emotional burden, expectation or interaction with another *Being with* them at the time of the reflective activity.

4.5.4 Phase Three - Second Interviews

The second interviews were carried out four to six months after the first interviews and were arranged at a mutually convenient time and location for the participants. The interview structure adopted Gibbs' reflective cycle but was further developed from data generated from the initial interviews (Ajjawi and Higgs, 2007; Pereira, Kleinman and Pearson, 2003; Sjöström and Dahlgren, 2002).

In preparation for these semi-structured interviews, data analysis of both the first interview and written reflections were completed and helped inform the interview schedule. This facilitated opening warm-up questions and potential prompts, wording and ideas which were then returned to during the second interview. Without wanting to present too much data from the first interview, I was

aware it was possible that participants recall could undermine their disclosing of new insights in the second interview.

I pre-prepared a reference pack, prior to the interviews, which included quotes, terminology, and emerging themes from the previous interviews and reflections with each individual participant. This enabled referencing to previous data dependant on the route taken by participants on their reflective journey. This cooperative back-referencing, clarification and reinterpretation can be related to the *Hermeneutic Circle* which illustrates the inextricable link between participants and the researcher in a phenomenological study (Clarke, Butler and Mayers, 2009; Smith, Flowers and Larkin, 2009) and is key to interpretive, as opposed to descriptive, phenomenology. The *double hermeneutic* in which the experience is initially interpreted by the person who is experiencing it, namely the participant and secondly by the researcher, is demonstrated through the interview then followed by analysis. This iterative process was continuous and, as such, had no end point and no single answer or truth. Rather than being purely descriptive, this interpretive approach embraced a deeper level of analysis (Smith and Osborn, 2015; Smith, Flowers and Larkin, 2009). This indeed enabled a repetition of increasingly rich analysis with new interpretations each time.

Supervision team feedback at this point focused on how I had not anticipated such premature level of depth in the first interviews. This led to necessary adaptations to the second interview schedules. The first interview aimed to build rapport through empathetic techniques such as active listening, eye contact, and showing an understanding through appropriate responses and questioning (Fontana, 2008). The second interview served two purposes. Firstly, to maintain

longer engagement with participants for further saturation in which I adopted a more focused approach seeking clarification of concepts. Secondly, it can be argued that these methodological processes may add to the rigor (Finlayson, 2016). The interval time not only allowed reflection on emergent themes for both interviewer and interviewee (Jacob and Furgerson, 2012), but also for participant consideration of wider issues around their role and patient safety. The monologue of thoughts and reflections at the opening of the second interviews were evidence of deeper reflection on the phenomenon in question over time. An excerpt from post-interview reflective notes on interview flow are seen below in Figure 2.

November 2016 Going off-track....

During the interview Catherine's reflections were flowing when she stopped say "sorry have I gone off-track…?" but I <u>wanted</u> her to go off. Whilst I was wary to keep an eye on the research aim, I am journeying with her, aware of where we had come from and where we may be going to; yet I was not, and tried not, to be in the driving seat.

Figure 2: Reflexivity Box 2

4.5.5 Reflexive Journal

A reflexive journal was kept throughout the process. These reflections punctuate, support and have run alongside the process throughout. Reflexivity refers to the assessment of the influence of the investigator's own background, perceptions and interests on the qualitative research process (Krefting, 1991). This journal served as a methodological log about my*self* as the human instrument used and it provides

information on the method (Lincoln and Guba, 1985). It was a place to record my thoughts, questions and other comments during the process as an audit trail to decisions made. Recording such details was essential to data collection and helped ensure that specific insights and discoveries were not lost according to Gerstl-Pepin and Patrizio (2009), as it gives a greater awareness of how knowledge is produced.

This journaling included reflexive notes pre- and post-interviews and was very much part of the process of the data analysis. Indeed, Lutz and Knox (2014) advise note-taking both during and after interviews. Taking notes during the interviews was, at times, challenging as I wanted to remain actively listening to the participant. Nevertheless, it helped me to remain actively engaged in the process and, furthermore, proved helpful later in the data analysis (Seidman, 2006).

Heidegger views people as essentially *inauthentic* and believes that increased *authenticity* can only be achieved when one pays attention to how our thoughts and behaviours about ourselves are influenced by our social surroundings. It is my interpretation that this journal is an explicit, transparent attempt, by me, to be as *authentic* as possible throughout the process. Excerpts from this journal have appeared above and will continue to appear throughout this thesis in the form of reflexivity boxes.

4.6 Data Analysis

The aim of data analysis is to find the meaning of a phenomenon by taking the information collected between the researcher and participants and reconstructing them into meaningful wholes (Lincoln and Guba, 1985). The aim of Heideggerian IP

has its focus in exploring the lived experiences in order to describe, understand and interpret participants' experiences whilst recognising the link to social, cultural and political contexts (Flood, 2010). In this context, the focus of data analysis was concerned with the understanding of *how* the *everyday lifeworld* of ANPs who are managing risk and safety, is constituted. Heideggerian phenomenology is consistent with a contextualist position (Larkin, Watts and Clifton, 2006). *Being in the world* as understood from a Heideggerian stance reflects a marriage of the human being's subjectivity and the objectivity of the world in which they exist (Heidegger, 1962), thus both world and being are viewed as inseparable.

The analytical approach used was that described by Van Manen (1990). This was chosen because it was felt that the all-encompassing approach to data analysis in which the descriptive elements remain, is an important element of the analysis and would enhance the ultimate interpretative understanding. A summary of elements of analysis can be found in Appendix 11.

Van Manen's (1990) work has influenced a great deal of research in nursing and education (Paley, 2016). Van Manen (1990) has been used in combination with Heidegger in several studies (Glenn, Raine and Spence, 2015; Smythe and Spence, 2012; de Witt, Ploeg and Black, 2010; Donnelly and Wiechula, 2006). Donnelly and Wiechula's (2006) study on patients' experiences of tracheostomy tube changes, combined the Heideggerian philosophical approach with Van Manen's analysis and found this approach to be effective in gaining good insights. De Witt, Ploeg and Black (2010) looked at interview data of patients' experience of dementia. This was analysed using Van Manen and Heidegger's philosophy which informed the interpretation of findings. Similarly, Smythe and Spence (2012)

combined Van Manen's analysis with Heidegger's philosophy in order to understand the phenomenon of tact within post-natal care. Glenn, Raine and Spence (2015) used a similar approach to investigate patients' experience of mandatory weight loss during the wait for bariatric surgery. These studies are evidence that the Van Manaen analysis can be successfully used with an underpinning of Heideggerian phenomenology. Jefferies and Clifford (2012) studied the lived experience of patients suffering from cancer of the vulva using an IP approach based on the work of Heidegger and Van Manen. As with most of the other studies described above, Jefferies and Clifford (2012) used a further theoretical framework to guide analysis in one case, as described by Ray (1994). Whilst these studies are evidence that these two approaches can be used in generating new knowledge, for this research it was felt that a further framework may dilute the essence of the philosophical underpinnings intended for this piece of work.

Van Manen's thematic analysis was chosen, as the process described was found to be clear but contained a flexible approach. It was, amongst others, the one that made sense and worked with the different sources of data collected. De Witt, Ploeg and Black (2010) found that Van Manen's (1997) method guided the simultaneous and iterative data collection and interpretive analysis of the meaning of their phenomenon of study of living with dementia. Indeed, this research design enabled iterative data analysis through multiple phases of collection; the first phase being analysis of the first interviews, then of the reflections resulting in initial ideas and theme building which in turn informed preparation for the second interviews.

The second interviews were analysed in isolation and then collectively analysed with all data sets for each participant.

The initial stage of comparative analysis for this research involved isolating the three data sources (two interviews and written reflections) for each participant. The final stage involved a synthesis of the collective analysis of all the individual *lifeworlds* in order to form a collective interpretive understanding of what the lived experiences of ANPs managing risk and patient safety in practice embraced.

Although Van Manen's analysis sits within hermeneutic IP, its use may be challenged, as it does not disregard the descriptive element of the process. Indeed, Van Manen (1997) acknowledges that both description and interpretation of the existential meanings of lived experience are valued aspects of the phenomenological philosophy. Paley (2016) refers to Van Manen (1997) drawing on both descriptive and interpretive traditions as being a "best-of-both-worlds" philosophy. Van Manen's analysis is justified as the descriptive elements of the interpretive phenomenological approach will seek depth through the focus on language and interpretation. In line with an adaptation by de Witt, Ploeg and Black (2010), Van Manen's reflective technique of free imaginative variation was omitted as this feature relied heavily on the descriptive school of phenomenology rather than the interpretive (Ray, 1994).

Van Manen (1990) rejects the idea of method, which may be followed in a sequence of steps, preferring the term *methodos* referring to a methodological ground for human research that should not be followed slavishly (Paley, 2016). For the purposes of clarity, Van Manen set out his steps, as outlined in appendix 12. However, it is important to note that for Van Manen, data analysis was not a linear

process. True to Heidegger's philosophical underpinnings, this analysis was not a step-by-step method, but rather a dynamic interaction between the research activities such as commitment to a concern, investigation of the lived experience, writing, rewriting and ongoing interpretation. In contrast to a chronological process of predetermined steps, through its revolutions, it became a flexing, changing, adaptive process, moving along its iterative path and continuing to evolve throughout. Van Manen (1990) states that "A phenomenological description is always *one* interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even potentially *richer* or *deeper* description". Within the *Hermeneutic Circle*, the reading, reflective writing and interpretation is not fully possible without the descriptive elements from both the researcher and participants. Figure 3 shows a thematic representation of the analysis used.

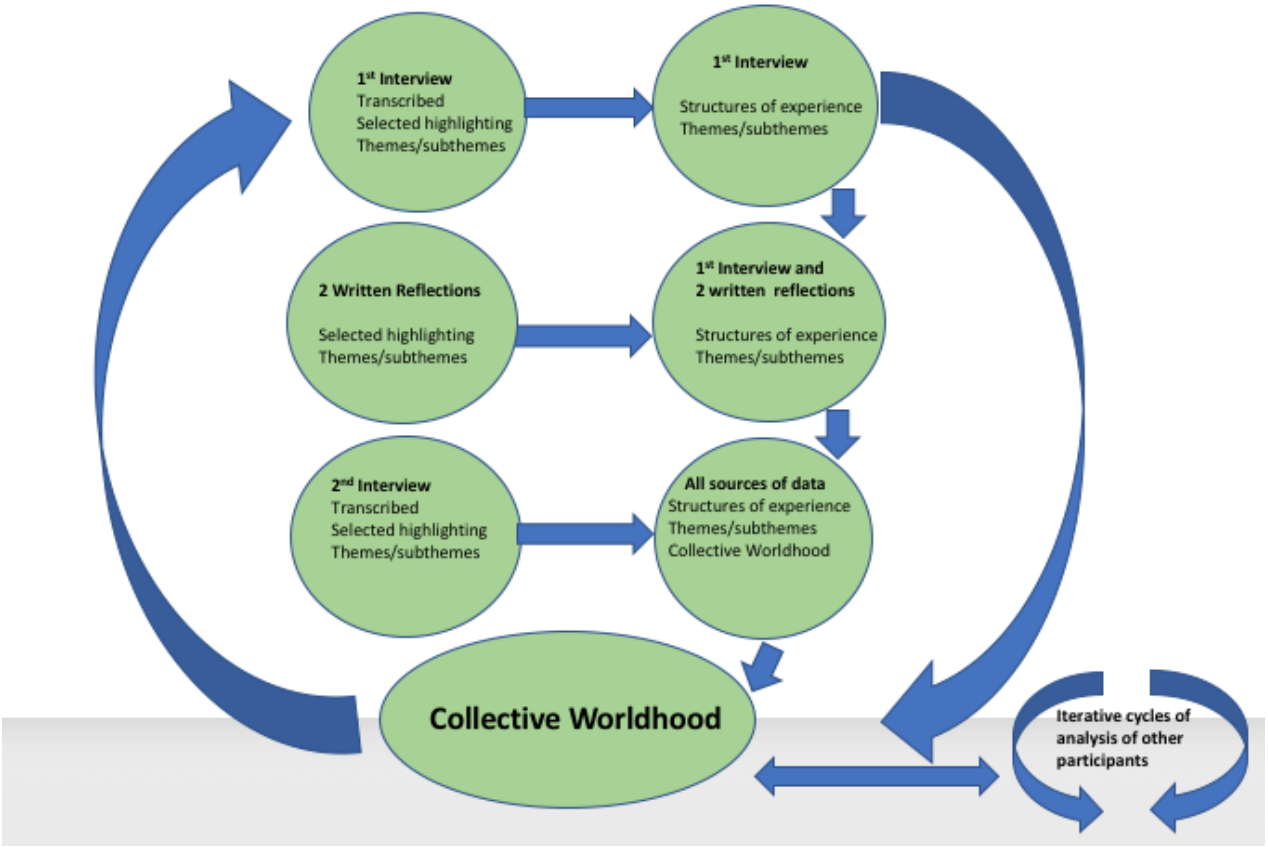


Figure 3: Conceptual Representation of Analysis

In alignment with Van Manen, data was analysed using a holistic approach in which each interview or reflection was read in entirety to grasp overall meaning. During the first phase of interviews, each interview was transcribed verbatim as soon as possible after the interview; this facilitated total immersion. This process was followed by comparing with the original recordings to ensure the "integrity of the narratives" (Crist and Tanner, 2003). Analysis began immediately through log writing, recording ideas, and constant comparative analysis. This was followed by reading and re-reading the transcripts line-by-line and then selective highlighting of significant sections of the text relevant to the research aim. Transcripts were approached with an open mind and various passages, phrases, or words of perceived interest were highlighted. Seidman (2006) suggests that the first step is

to read the text and mark the passages that are interesting. The selective highlighting through the NVivo 11 software package enabled annotations to be made on this highlighted text. Multiple units of meaning were derived and interpreted individually through annotation. The transcripts were re-read, and those units of meaning were interpreted and thus illuminated the phenomenon of ANP management of risk and patient safety.

Identification of themes and subthemes were generated from codes which were clustered together through repeated readings and coding of the transcripts (Quinn, 1998). Van Manen (1990) describes thematic formulations in which *meaning* applies to the whole description, rather than units of meaning or any segment of data. Creswell *et al.* (2007) recommends establishing five or six main themes along with sub-themes. According to Van Manen (1990), "phenomenological themes may be understood as the structures of experience". Following Krefting (1991), the material was coded, set aside for a couple of weeks and then recoded again. This process was repeated with the written reflections, where themes were derived. These codes were grouped into themes.

Once the two written reflections were received, the same analysis took place via the iterative process, as described above for the first interview. Following this, those units of meaning and themes were assimilated with the existing units and themes from the first interviews. Key themes anomalies, changes and differences were noted.

The analysis of the first interviews and reflections assisted in the development of a modified structure for the second interviews (Boyd and Lawley,

2009; Garrow and Tawse, 2009; McArthur-Rouse, 2008; Barlow and Antoniou, 2007) . Thus, the themes/ideas were returned to in the second interviews to facilitate enquiry of underlying interpretations and understandings (Bourne and Robson, 2009). This subsequently led to shared interpretation between participant and researcher. The second interview began with general open questions as to whether the participants had any thoughts or feelings about their experiences of managing risk and safety since the previous meeting. There was then an opportunity for them to discuss their written reflections and what specifically arose for them. This was followed by transcription of the second interview analysis, following the same process as used for the first interview.

Following a process of listening, re-listening, reading, re-reading, coding, re-coding, theme building and rebuilding with ongoing reflexivity, the final themes were established. This process led to interpretation of meaning, insightful invention, and discovery, through a free act of "seeing" themes emerge; experiential themes recur as "commonality or possible commonalities" Van Manen (1990). Heidegger (1962, p.96/67) refers to this as themes *coming alive* when you put yourself in a position of concern. The codes, themes and subthemes from all the sources of data from all participants were assimilated together from which final themes and subthemes were derived, refined, and anomalies and differences interpreted. Once all data from one participant had been analysed, an interpretive description of that participant's *lifeworld* was achieved in the form of a narrative.

This process was assisted by the use of NVivo 11 in which codes generated from sections of the text were grouped according to subthemes and themes. Use of the NVivo software was carefully considered as it may be criticized for

overreliance on technology; however, it has previously been used in similar studies (De-Witt, Ploeg and Black, 2010) and found to be invaluable in assisting in managing large amounts of data across multiple data sources. Use of Computer Assisted Qualitative Data Analysis Software (CAQDAS) in phenomenological research is contentious (Goble *et al.*, 2012). Heidegger's (1977) own assertion was that with the use of technology, we can become functions of it. Goble urges researchers to consider carefully the impact of how software such as NVivo can alter our *Being-in the world* of research. The decision to adopt this approach was carefully considered for this reason. Indeed, the early stages of analysis was carried out outside of NVivo including transcribing, reading, selecting codes and deriving early themes of the first interview. Reflections was carried out largely outside of NVivo 11, however, following the second interviews, all data was imported into NVivo 11.

To draw conclusions from the data, it is important to achieve a collective understanding of all the findings. Thus, I carried out this cross analysis between the different data sources for each participant. Cross tabulation involved comparing the information from different sources and participants, and the use of NVivo assisted this final stage of analysis as a way of organizing the multiple sources of data, memos, and previous analysis. Codes were not generated using the software. The codes and the themes were derived by myself, as the researcher, and links between the codes and themes were also created manually by me. The NVivo 11 software, rather than generating codes, was used to facilitate cross organization of the themes and the codes across all the data. Use of this package enabled me to keep a grasp of the data as a whole, being close and easily retrievable. It also

facilitated me to remain true to the philosophical foundations of Heidegger (1962) without being distracted by complexities of accessing and organizing the vast amount of data that this study harvested. Figure 4 is a visual representation of this approach of analysis.

Figure 4: Visual Evidence of Analysis and Theme Building

Van Manen (1997) notes that searching for the meaning of a phenomenon requires "…reflectively analysing the structural or thematic aspects of that experience". This is followed by a process of extraction and interpretation, with consideration for the holistic understanding (Smith, Flowers and Larkin, 2009; Van Manen, 1997). This understanding was developed on the basis of Heidegger's *fore-*

structures of understanding, such as what is already understood about the management of risk and safety by both practitioner and researcher. As the researcher, I am part of the shared process as each of the interviews were bound historically, politically and contextually through my own experiences (Fontana, 2008). Indeed, Heidegger (1962) refers to *fore-having*, *fore-sight,* and *fore-conception*. As such, my *fore-having* is the familiarity and background as an ANP, the *foresight* is my point of view from a social cultural background, and *fore-conception* provides the basis of anticipation and each of these elements - the basis from which, interpretation took place. The temporal nature of data collection and iterative nature of analysis achieved a layering of repeated interpretation throughout the three structures of experience for both the participant and myself over a period of time. This enabled a richer deeper shared understanding of the phenomena of the management of risk and patient safety in ANP practice.

4.6.1 *Lifeworld's*

Once themes had been identified for each participant, a descriptive interpretation of that participant's *lifeworld* was created. In discussing "how-the-worldly-character-announces-itself", Heidegger (1962, p.106/75) theorizes that if an entity *comes alive* or *lights up*, it must have been disclosed beforehand and, therefore, as it was already there, this process of illumination is simply what can be described as coming back to their *lifeworld*. It is clear how, within this familiarity, the researcher's *Dasein* might "lose itself in what it encounters within-the-world and be fascinated by it" (Heidegger, 1962 p.107/76). Thus, this interpretive understanding

comes from a connection between the participant and researcher. Heidegger's philosophical approach guided the analysis through all the stages. The discursive descriptions remained with the terminology, as used by that specific participant. This had the advantage of staying true to participants interpretations and our shared interpretations during the course of the interviews. Heideggerian terminology was not explicitly used in the interpretive descriptions until the collective *lifeworld's* were laid out. This was felt to be the most authentic to participant's individual *lifeworld's* as they, themselves, the individual, understood and interpreted it.

Having formulated an interpretative description of each individual *lifeworld,* an interpretation of the collective *worldhood* was achieved though the collective themes in order to collate the findings into a meaningful form. The synthesis of collective *lifeworld's* involved cross analysis in which a creative process of identifying categories and common themes across cases would be achieved through organizing a conceptualizing data to see how it clusters into themes (Ladany, Thompson and Hill, 2012).

4.6.2 Phenomenological Knowledge

Phenomenology has been criticized for having no practical value, and what can be done with phenomenological knowledge, has been questioned (Paley, 2016). Van Manen (1990) asks if phenomenology can do something with us. Van Manen (1990) refers to research as a caring act, asserting that one can only understand something or someone for whom we care. Paley (2016) questions if knowledge can have its foundation in love and asserts that this surely leads to mystery and

warns that “anyone looking for a rigorously analytical text book should approach with caution”. Indeed, according to Goble (2014) these analysis activities, described above, are not guaranteed to result in a phenomenological reflection. The “how” must be found anew with each study (Manen, Higgins and Riet, 2016) making phenomenological researchers “perpetual beginners” (Merleau-Ponty, 2013). On reflection, it is possible that another approach such as IP Analysis (IPA) described by Smith, Flowers and Larkin (2009), with its step-by-step approach would have achieved the richness of analysis of that of Van Manen. Whilst initially drawn toward the pre-prescribed, exacting steps of IPA, the less prescriptive and more-open-to-interpretation Van Manen approach afforded the freedom to be led more by the data rather than being process led. This less exacting and organic journey potentially may have afforded a more open approach with greater possibilities of circular interpretation.

4.6.3 Data Analysis and the *Hermeneutic Circle*

The *Hermeneutic Circle* is evidenced through continuous reading, re-reading, listening, reflective writing and interpretation (Laverty, 2003). Specifically, data analysis is an ongoing and iterative (non-linear), cyclical process collecting, analysing, revisiting data throughout the research study. According to Heidegger (1962), it is within the circle that there is a hidden positive possibility of the most primordial kind of knowing. The aim of the *Hermeneutic Circle* (see Chapter Three) is for incremental understanding to animate inventiveness and stimulate insight to achieve the Heideggerian focus of return "to the things themselves" to its origins as "groundless ground”; thus, working at “mining meaning…unearth something

'telling,' something 'meaningful' something 'thematic' in the various experiential accounts" (Van Manen 1990). There is clear evidence of the *Hermeneutic Circle* as demonstrated through returning to presuppositions and potential emerging themes in the second interviews and iterations of interpretive analysis throughout the data collection and analysis. Figure 5 visually exemplifies how the design of this research seeks to align with Heidegger's philosophical underpinnings:

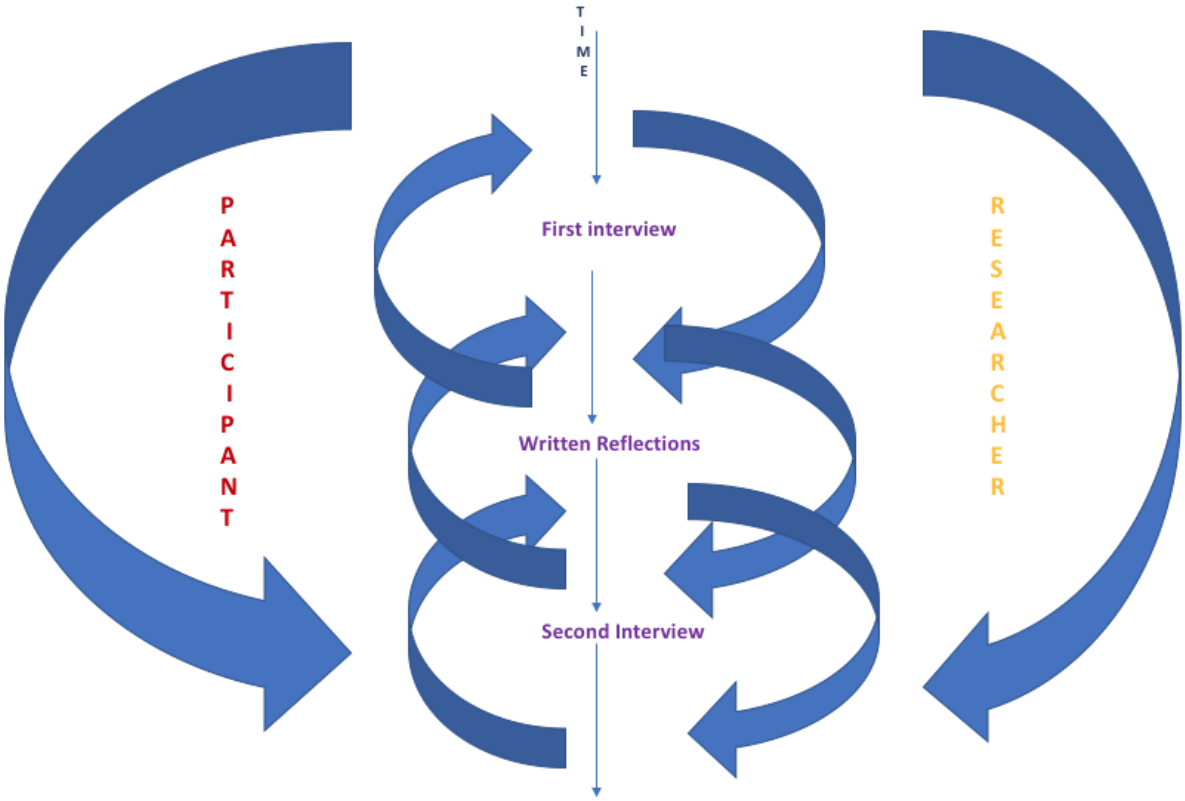


Figure 5: Alignment of this Research to Heidegger's Philosophical Underpinnings

This diagram demonstrates how the *Being* of the participant and the *Being* of the researcher is moving through time within cycles of interpretation. The cycles of shared interpretation of risk and safety occurred within space (*clearing*) that the

first interview created between the participant and the researcher. Each of these *Beings* in their existence (*Dasein*), bring with them their *forehaving* (previous experience/knowledge/understanding) to create the condition for *foresight* (having a point of view from which interpretation can be made). The endeavour being to move from basic *everyday* understanding towards *interpretation* of the phenomenon of managing risk and safety. *Being-with* each other in *discourse* and absorbed in shared concern of this phenomenon aims to reveal that which is concealed through an enlightened understanding. This understanding was deepened by layering the circles of interpretation though time with the written reflections and then the second interview. The circular nature of interpretation, iterations and reiteration were thus enabled and embedded within this research design. For example, a conceptual understanding that existed at the time of the first interview, may be returned to in the reflection and then again in the second interview. Each time it is revisited, it is reinterpreted, and done so in a way that belongs to the context and the perspective of that *Being* in that moment in *time*. This research design essentially seeks alignment with Heidegger's key concepts of *Being* and *Time*.

The *Hermeneutic Circle* of analysis carries some contention, as Heidegger (1962) himself refers to the circular argument stating that circular proof in the existential analytic cannot be avoided because this analytic does not prove through logical consistent rules. The question to consider is whether there is knowledge without experience. Nevertheless, Heidegger (1962 p.363/315), advises that "we must endeavour to leap into the 'circle', primordially and wholly, so that even at the start of the analysis of Dasein we make sure we have a full view of Dasein's

'circular Being". Thus, remaining in the circle through recollection and repetition is grounded in interest. As the researcher, I made the metaphorical leap into the circle and, through a phenomenological hermeneutic lens, sought the view of the circular being of the *Dasein* of each participant.

4.7 Trustworthiness and Rigor

As with qualitative studies, demonstrating the process of establishing trustworthiness and rigor of inquiry is an essential step to the whole endeavour, if the outcomes are to benefit the community. Speziale, Streubert and Carpenter (2011) wrote that the goal of rigour in qualitative research is to accurately represent study participants experiences. According to Lincoln and Guba (1985), trustworthiness is a multifaceted process that requires attention to a number of aspects and should be judged on the following: credibility, transferability, dependability, and confirmability. The latter approach to assessment of trustworthiness aligns with the positivist framework for quantitative research. Integrating this assessment framework is an attempt to demonstrate trustworthiness both from a qualitative and quantitative lens to seek wider credence of the credibility of this research design. Rigour in qualitative research is established through the studies credibility, transferability and confirmability (Speziale, Streubert and Carpenter, 2011; Cutcliffe and McKenna, 1999; Sandelowski, 1995; Lincoln and Guba, 1985). These will frame the following discussion.

4.7.1 Credibility

Credibility requires the researcher to clearly link the research study's findings with reality in order to demonstrate the truth of the research study's findings (Shenton, 2004). It is considered the most important of the elements of trustworthiness (Lincoln and Guba, 1985). Selection of highly credible experienced participants who were able to inform, contributes to the aims of the study sought to enhance credibility. According to Shenton (2004), honesty is preserved by allowing participants to refuse to answer any questions or to withdraw from the study at any time. Whilst both these points were clear to the participants, there can be no real certainty of preservation of honesty, as is the nature of the self-reporting qualitative method of data collection.

Techniques such as member-checking and triangulation enhance credibility (Noble and Smith, 2015). Credibility is enhanced by the triangulation of sources of data collection, and in using multiple sources of data collection, for example, two interviews plus two written reflections. Use of multiple data sources over a period of time also increases credibility.

The multiple sources of data such as the interviews and reflections gathered over a period of time enabled discussions on elements previously referred to, can be considered a form of *member checking*; similarly, so could the discussions in the second interview of the reflections and elements of the first interview. Taking this information back to the participants assisted with the subsequent interpretation (Creswell *et al.*, 2007; Shenton, 2004; Lincoln and Guba, 1985) and shared understanding.

Prolonged engagement and persistent observation can increase credibility (Lincoln and Guba, 1985). As discussed previously this study cannot be considered to be strictly either of those terms, however the benefits of the longer engagement than a single point in time may achieve some of those benefits of credibility, even if to a lesser degree. From the first contact in September 2016 to the final interview in June 2017, there were between seven and ten months of engagement. This involved initial email contact, subsequent phone calls, the interviews themselves, and included *touch-base* communication for the purposes of receiving written reflections. Such contact and interactions all served to develop rapport and prompted the participants to consider and reflect about the topic in question. Indeed, ensuring adequate time in between each interview, aimed to prevent the possibility of missing emerging themes and sub-themes (Duffy, Ferguson and Watson, 2004). This, I believe, enhanced the subsequent data received as it came from a period of engagement of this research, and from a place of deep reflection at different times over a period of time. This aligns with the Heideggerian principle of *temporality* (Heidegger, 1962); the essence of the participants *Being* can only be understood in the context of *time* and, indeed, can be directly related to the title of his work *Being and Time.*

Saturation of the data is additional proof of trustworthiness (Bowen, 2008). Williams and Morrow (2009) refer to data saturation as “themes or categories that are fully fleshed out reflecting the depth and complexity of human life”. Analysis generated multiple codes and themes across the data, thus, it was clear that there was an overlap with multiple themes suggesting saturation. Arguably saturation is

not achievable, or the goal of IP as iterative interpretations achieve emergence of alternative understandings.

Whilst giving many elements of similarity to this phenomenon, it was clear from the participants that there were also diverse perspectives too. As a researcher, it is important to recognize that diverse or *deviant* perspectives shared in different forms can ultimately lead to rich data (Williams and Morrow, 2009). An example of this was an early assumption or emergence from the data that it was necessary to *care* for a patient in order to manage risk and safety effectively. However, as the data emerged over the process of data collection and between participants, an anomaly appeared. It was only due to the iterative interpretations that this deeper understanding of the hidden assumptions of this concept was revealed. It is the process of revealing that which is concealed or hidden, that is a key feature of the Heideggerian approach.

Indeed, towards the end of the first phase of interviews, a theme of a prerequisite of *caring* for the patient in order to manage risk effectively was emerging. However, in a few of the later interviews, there were strongly contrasting opinions about this notion. This led to re-evaluating and the emergence of a new understanding of this element of the phenomenon, which led to an interpretation at a new level of depth.

4.7.2 Transferability

Lincoln and Guba (1985) refer to the importance of transferability of research. It is important that researchers provide the necessary information that makes transferability judgements possible. Therefore, it is important that sufficient

information is provided to the reader. Specific information regarding the participants such as demographics, age, gender, years of experience as an ANP, and the site in which they work was presented to allow the reader to make their own judgements regarding transferability of the findings of the research (Hill, 2012; Shenton, 2004; Krefting, 1991; Lincoln and Guba, 1985).

Despite the small sample, potentially this research could be applicable to a range of contexts, situations, and populations. The findings from this research may be applied to other professionals who work in similar environments, various practice settings, or who have a similar workload pattern. The focus of this inquiry, together with the demographics, provides a measure of transferability across range of healthcare professionals and settings including other areas involved in managing risk. Furthermore, the rich descriptions achieved of the phenomena in question will also be critical to the enterprise of demonstrating this transferability, as will the connections made between the findings and professional, policy and cultural contexts with regard to the support and educational development of ANPs.

4.7.3 Dependability

In qualitative research, dependability refers to the consistency of the data (Krefting, 1991). To achieve this, it is important to explain the process of data collection and analysis (Shenton, 2004) so that the reader will be able to have a full understanding of decisions made through the process (Krefting, 1991). An example of this is the logging and record of changing codes and themes during the different stages of the analysis process. Indeed, collectively through the process, there were over one hundred themes through the method of analysing all the data sets, first

individually, then in collective data sets per individual, then again with the synthesis of all the data sets across all the participants. The "overlapping methods" (Krefting, 1991) of the interviews and written reflections, particularly in the second interviews where the participants also discussed the first interview and the written reflections, further enhancing dependability.

4.7.4 Confirmability

Confirmability addresses the researcher's attention or concern to objectivity (Shenton, 2004). This can be enhanced through activities such as triangulation of the different data sources, the reflexive, and the NVivo software, which provides an audit trail of analysis. Whilst the use of NVivo software may be considered contentious by purist Phenomenologists and was challenged by one of my supervisors, I remain aligned to the view that it facilitated a checking process in storing and organizing the vast amount of data and, in particular, logging and time-framing the analysis in a comprehensive way. It ultimately served as an evidence record of evolving units of meaning of the words, phrases, and pieces of information taken from the data that ultimately formulated part of the themes. Finally, support from the supervisory team, such as sharing the analysis process, asking them to blind-read the transcripts to identify themes, and then sharing analysis for them to challenge is further triangulation (Schielke *et al.*, 2009) and, thus, confirmability to objectivity.

4.7.5 Rigor

Rigor and trustworthiness is achieved through a sound research process, good participants, and reflexivity achieved by using a researcher diary throughout (Lincoln and Guba, 1985). According to the DH (2005), quality in phenomenological research relies upon the researcher being qualified, equipped with the skills, experience and appropriate support to use their professional judgment effectively in the delivery of a dependable research project (DH, 2005). As evidenced through the supervision meeting log and the reflexive diary, rigor has been endeavoured to be achieved by the thoroughness in collecting data, through being open to that data, and through scrupulously adhering to my interpretation of Heidegger's IP perspective.

According to the Department of Health (DH), research which is not of sufficient quality to contribute something useful to existing knowledge, is unethical. Researching a topic contested by some as to its authenticity might be questionable. Quality research culture is about promoting high quality research for the development and implementation of best practice in the delivery of care (DH, 2005). Greater knowledge of how ANPs manage risk and safety will facilitate a better understanding of practice. This is an area that has not been studied itself, and the IP method enables this much needed critical focus.

There are long-standing debates on quality-assurance and what constitutes rigor and "quality" in qualitative research (Reynolds *et al.*, 2011). Indeed, principles of Good Clinical Practice (GCP) are applied with greater ease to quantitative health-science research. The lack of a unified approach to assuring quality can prove unhelpful for the qualitative researcher (Dixon-Woods *et al.*, 2004; Barbour, 2001).

Issues of rigor are raised with a small, non-generalizable study using a non-probability sampling, self-report method, as no conclusions can be drawn about participants' actual behaviour; it is therefore less representative and rigorous in terms of consistency (Trochim and Donnelly, 2006). This is a recognized limitation of phenomenological enquiry. Nevertheless, it is the contention that the benefits of an in-depth understanding of ANPs managing risk and patient safety gained from the richness of the data in this research is clear validation of the chosen approach.

4.7.6 Limiting Bias

In this study, I endeavoured to reduce the imposition of personal biases and convictions. It is important to be clear on this point that true to the Heideggerian IP, these biases were not bracketed, as would be the guidance and intention of a researcher following a DP method. It is my contention that bracketing my knowledge and beliefs is not only unachievable but would not highlight the potential possibilities of a depth of interpretive understanding of this phenomenon from the perspective of an insider. Indeed, insider knowledge was used as an aid to interpretation and understanding whilst keeping a heightened awareness of those biases through reflexivity and support from the supervision team. With a team of three supervisors from varied backgrounds, this afforded me with a "variety of viewpoints", which can help to "circumvent the biases of any one person" (Hill, 2012).

4.7.7 Insider Perspective

It is important to note that nurse-researchers who are already immersed in the organization have a pre-understanding from being an actor in the processes being studied (Coghlan and Casey, 2001). Indeed, it could be argued that my pre-understanding of organizational roles, such as an ANP and hospital policies, is likely to have steered the political process of framing and selecting this research project. The fact that I am an ANP has implications for the implementation of this research. This "insider's perspective" of a qualitative researcher researching in their own setting can threaten the trustworthiness of the study (Asselin, 2003). Indeed, several participants acknowledged this insider perspective through comments such as *"you know what it's like…",* thus, assuming that my insider knowledge meant explanation or simplifying was not necessary. In these circumstances it was important to acknowledge this. Consistently clarifying meaning ensured nothing was lost when an understanding might wrongly be assumed. Furthermore, a few of the participants were known to me professionally, and this is recognized as having an impact with regard to responses and what the individuals may disclose (Bonner and Tolhurst, 2002). To address this, it was important that the study was conducted with respect, self-awareness of the researcher's presence and the potential effect on the research (Bourne and Robson, 2009; Mercer, 2007; Bonner and Tolhurst, 2002; Chesney, 2001).

It is imperative for qualitative researchers to situate themselves in the research (Ely and McCormack-Steinmetz, 1991). As an "insider" with a comparable level of experience with the participants, I reflected in the journal that this may enhance subsequent depth and breadth of data (Asselin, 2003; Kanuha, 2000) as

participants are typically more open with insiders (Edwards and Talbot, 1999). This connective relatedness of the participants' *lifeworlds* and of the researcher's *Dasein* is perhaps a factor in positively aiding towards a shared interpretive understanding of the phenomenon. However, some argue that there are challenges to the insider perspective, asserting that there may be some legitimacy and/or stigma related such as heightening researcher subjectivity that may be detrimental to data collection and analysis (Sidebotham, 2003; Serrant-Green, 2002; Adler and Adler, 1987). There may be some confusion (Asselin, 2003) with regard to role conflict (Brannick and Coghlan, 2007). Challenging the dichotomy, Dwyer and Buckle (2009) discuss the space between insider and outsider status in which the position of being a qualitative researcher is *being-with* the participant. Furthermore Dwyer and Buckle (2009) suggest that as researchers may lean towards either insider or outsider, they can only occupy the space in between because their perspective is shaped by the experience of being in the position of researcher. Acker (2000) supports the notion of being both, and advocates that the researcher should work creatively with the tension of the space in-between. An example of reflexivity on the potential impact of the dynamics of an insider perspective can be seen in Figure 6.

May 2017 Can you write it up for me? Abigail

Upon sharing a transcription with my supervisor asked what was meant by a participant jokingly saying, "can you write it up for me?" as I was thanking her at the end of the interview. What does this mean?" I was asked – nothing I thought. This was no bargain it was a shared understanding of the mandatory need to write up reflections, but our discourse is on a level that can exclude understanding of others. It was not obvious to my supervisor but obvious to me. Nevertheless, reflections since have led me to question dynamics of familiarity of being and insider and how this impacts interaction.

Figure 6: Reflexivity Box 3

4.8 Ethical Considerations

Ethical considerations are paramount in research. The maxim "above all, do no harm" is encompassed by the ethical principles of beneficence and non-maleficence (Eddie, 1994). Couchman (1990) identified key ethical considerations including confidentiality: informed consent; right to self-respect; dignity and not to be harmed; and familiarity of research setting. This study was conducted with respect for the participants' awareness of my presence as the researcher, and its potential impact on the research (Mercer, 2007; Bonner and Tolhurst, 2002). Ethical consideration will be discussed in terms of: The ethical approval process; confidentiality; data protection; informed consent; and a discussion on the ethics of researching clinical risk.

4.8.1 Ethical Approval Process

Ethical approval was sought through the University's Research Ethics Committee. The approval letter with conditions was received in July 2016. Following

confirmation of the necessary changes required, such as consistent terminology, full approval was given in August 2016 (Appendix 13). Access to the three sites (A, B and C) took place as described above previously. Prior to accessing participants, a research governance form and risk assessment form was completed as part of the University Ethics process in conjunction with the Director of Studies.

4.8.2 Confidentiality

All data was anonymized and kept on a password and encrypted computer. To preserve anonymity and confidentiality, all participants were given pseudonyms and any reference to the healthcare site removed. According to Seidman (2015), this is an aspect of good practice in research to protect the confidentiality of the patient. Confidentiality is one of the responsibilities of a researcher and professional commitment to the participants (Mercer, 2007). Confidentiality is defined as the responsibility for information obtained in the interaction between the professional and the client (Boschma, Yonge and Mychajlunow, 2003). The privacy of information gathered on each research participant must be respected and maintained. This was done by altering the forms of documentation, removing personal identifiers, and encoding data elements (Lin, 2009). The audio recordings were destroyed once transcribed, listened to, and once I was satisfied that saturation had been achieved.

Protecting information is part of a professional commitment; the obligation to maintain confidentiality is rooted in the clients' right to privacy and control of information (Lin, 2009). As part of a robust process, it is important that the participant be aware of all the measures in terms of data protection.

4.8.3 Data Protection

The new General Data Protection Regulation came into effect on the 25th May 2018 and was designed to reinforce DPA regulations whilst adding new aspects, such as cybercrime, commercial exploitation, and sensitive personal data for illicit purposes as well as higher maximum penalties for data breeches (Knott, 2018). In the context of this research, the data are the audio-recordings, interview transcriptions, communications, and field notes identifying, and related to, participants.

As recommended by Lin (2009), a rigorous procedure was put into place to protect the personal information of the participants or anyone involved. The Data Protection Act establishes participants' rights as paramount in ensuring their emotional wellbeing (Beck, 2002). An example of this is maintaining a focus on the research topic to avoid collecting any unnecessary data (Lin, 2009). It was imperative that those who have had contact with the data (i.e. the primary researcher and the three supervisors) were clear of their data protection responsibilities (Beck, 2002). All data was well organized, accurate, replicable, confidential, safe, and backed up, as recommended by Macrina (2005).

4.8.4 Informed Consent

Researching how different ANPs manage risk and safety is an area that is potentially sensitive and may be considered as exposing or an intrusion by some, thus raising ethical issues (Walker, 2007). Comments such as *"oh that makes me sound horrible"* or *"perhaps I shouldn't have said that"* are suggestive that this

might be the case. Deep exploration and exposure of a sphere of a person's consciousness, including thoughts and emotions regarding challenging judgements around risk and safety, may lead to feelings of personal exposure and vulnerability. Furthermore, ANPs discussing navigating clinical risk in the context of today's litigious healthcare may also lead to feelings of vulnerability. Nevertheless, such research is essential to the provision and development of effective, efficient and safe healthcare (Hardicre, 2014). Indeed, informed consent represents this permission to intervene on a person's private sphere (Cahana and Hurst, 2008). Informed consent is the central doctrine to any research which is based on the principles of autonomy and self-determination (Mandal and Parija, 2014). Parahoo (2006, p.25) defines informed consent as: "The process of agreeing to take part in a study based on access to all relevant and easily digestible information about what participation means, in particular, in terms of harms and benefits".

Adequate information refers to giving full information about the research so that the ANP's know exactly what they are consenting to (Hardicre, 2014), which may decrease anxiety (Cahana and Hurst, 2008). The International Conference on Harmonisation (ICH, 1996) outlined 20 elements of valid informed consent (Appendix 14) to include in Participant Information Sheets (PIS; Appendix 6), which should be provided and discussed with the ANP. Explaining potential benefits and risks is imperative (Mandal and Parija, 2014). Raab (2004) states, "If a subject enrols solely because of hoped-for benefits, any informed consent process has failed". Trust is a motivating factor for participation, the researcher must give true expectations (Cahana and Hurst, 2008).

Voluntariness refers to an understanding that ANPs have no obligation to

participate and are free to withdraw at any time without avoidance of coercion (Tomlin *et al.*, 2014). This is a difficult aspect of informed consent (Cahana and Hurst, 2008), as it requires greater conceptual clarity (Pace *et al.*, 2005). Results from a voluntary "opt-in" participant recruitment may not be generalizable; however, they may also be biased regarding participant motivation (Van den Broek, Nyklíček and Denollet, 2011; Kaptchuk, 2001).

Competence is defined as being capable of understanding what participation entails and having the capacity to make a free and informed choice. Researchers have a duty to ensure comprehension of information (Leisegang *et al.*, 2009). Decisional capacity (Dyer and Bloch, 1987) is the ability to make decisions after understanding the information provided (Bhatt, 2015) consisting of factual understanding, logical reasoning, communicating choice, whilst appreciating the significance of the decision (Appelbaum and Grisso, 1988). Consideration of mental abilities is preserved until serious medical reasons bring that to question "assumption of competence" (Bagarić *et al.*, 2014).

Taking consent once, at the beginning of the research, may risk later breaches, if continual consideration is not ensured through the whole process. Therefore consent should be a continuous process with regular participant updates (Mandal and Parija, 2014). The process of gaining informed consent has been referred to as burdensome (Nishimura *et al.*, 2013). Ethicists argue that informed consent should be adapted to the risks of research participation. This would require less rigorous consent standards in low-risk research, such as this project, rather than in high-risk research, such as clinical trials (Bromwich and Rid, 2013). It is clear that ensuring a robust, clear, transparent, process will uphold the

fundamental principles of autonomy and self-determination of the participants involved (Cahana and Hurst, 2008).

4.8.5 The Ethics of Researching Clinical Risk

The principles of GCP state that before a trial is initiated, foreseeable risks and inconveniences should be weighed against anticipated benefit for the individual trial subject and society (ICH, 2006). Thus, it is necessary to consider the ethical implications of researching how ANPs manage clinical risk. Managing risk and patient safety is high on public, political, and clinical agendas. The maxim "above all, do no harm" is encompassed by the ethical principles of beneficence and non-maleficence (Eddie, 1994). If uncertainty is irreducible in clinical practice, then managing risk is an inevitable reality of managing patient safety. Whilst the ethics of ANPs managing risk is complex for public understanding, it is clearly an area of research that is essential. This will have implications for research dissemination, as well as how this impacts both public and the professional community.

In considering Good Clinical Practice in research, the rights, safety and well-being of the trial subjects are important factors and should prevail over interest of science and society (ICH, 2006). A trial should be initiated and continue only if the anticipated benefits justify the risks (ICH, 2006). The proposed research is potentially sensitive, as it could expose ANPs to scrutiny or may be considered an intrusion causing professional vulnerabilities which raises ethical issues of respect for the subjects (Walker, 2007). Adhering to correct procedures with regard to informed consent and data management, as discussed below, will ensure the well-being of participants. However it was important to consider that there may have

been a necessity to breach participant confidentiality had there been disclosure of legal, professional wrong doing through a professional, personal or moral obligation and duty of care (Wiles, 2012).

Qualitative researchers must adhere to human/participant protection measures, as they are the most important part of the study. This was facilitated through rapport building, which aimed to develop a non-hierarchical relationship between myself as the researcher, and each of the participants (Lin, 2009). If researchers demonstrate inadequate respect for the data and privacy maintenance, then potential harm may occur through negative psychological impacts and feelings of regret for a story shared (Clarke, 2006; Hadjistavropoulos and Smythe, 2001; Langford, 2000).

4.9 Maximizing the Impact of Research Findings on Practice

In recent years, there has been increasing emphasis, placed by the government, on the requirement for evidence of economic and social benefit from research investment (Carroll and Shabana, 2010; Weiss, 2007). If the purpose of research is to produce original results (UEIS, 2014), the next consideration is maximizing the impact of this new knowledge in this field of practice. This, of course holds the assumption that all research is original and adds something new. Research Councils UK (RCUK, 2016) define research impact as "the demonstrable contribution that excellent research makes to society and the economy". It is therefore clear that the medical research and academic community is increasingly questioning how to measure returns on investment in health research (Frank and Nason, 2009).

Indeed, it is important to justify the societal value of the expense of this research (Carroll and Shabana, 2010; Weiss, 2007) and how key indicators in academic medicine may promote effective growth and development in a dynamic clinical training, and research environment (Joiner and Coleman, 2012). Accountability and good research governance is key for the stakeholders of such research, such as the University and Health Organization involved (Ovseiko, Oancea and Buchan, 2012). Impact considerations are that the potential beneficiaries of the research are identified, as well as identifying how to maximize the benefit on policy and practice. In order to do this, there needs to be a robust plan for maximizing impact, which includes being opportunistic during the course of the research and beyond (RCUK, 2016). This includes dissemination, publication and use of social media.

The benefits for society are through ensuring that decisions on policy and practice are informed by secure evidence. Indeed, the instrumental impact of research includes influencing the development of policy, practice or service provision, shaping legislation and altering behaviour. This research can help to improve the effectiveness and sustainability of the NHS, improve societies' understanding of healthcare provision with regard to ANPs, and the reality of clinical risk and patient safety. Potential further benefits are if ANPs have an increased ability to safely navigate risk, it may lead to less hospital transfers (Bowen *et al.*, 2014) or over-investigation (Ghosh *et al.*, 2012; Stahel *et al.*, 2010). This not only offers better quality and safer, more appropriate care, but also a significant financial benefit (Sajjanhar, 2011). Furthermore, there are many

benefits to understanding this risk adverse, litigious culture for both patient and society.

These are conceptual benefits, which contribute to the understanding of policy and potentially reframing debates around clinical risk and patient safety. A research intention is enhancement of public perception and understanding of medical science and scientific processes (Ovseiko, Oancea and Buchan, 2012) with regard to raising the profile of the reality of risk management in ANP practice and, indeed, illuminating what the reality of this experience is. This recognition of the high level of practice may benefit the nursing profession and will have implications for training future nurses. Indeed, this can be termed as capacity building through ANP/ACP skill development.

4.10 Summary

This chapter outlined this study's research methods with regard to design, participant sampling, accessing sites, data collection, data analysis, trustworthiness and rigor, ethical considerations, and a discussion regarding the ethics of researching risk. The next chapter details the findings.

Chapter Five - Findings

5.1 Introduction

The findings are presented in this chapter. This begins with a presentation of the *lifeworld* themes of the lived experience of managing risk and patient safety for each of the ten practitioners. This is followed a depiction of the collective *lifeworld* themes interpreted through a Heideggerian philosophical lens. Remaining with the individual data sets of each of the participants initially was a deliberate intention to remain true to individual representation of experience.

Interpretation in German (Auslegung) translates as *laying out* (Inwood, 2000). According to Pattison (2013), the *laying out* of an issue in Heideggerian terms is "to enable it to be seen for what it is". Thus, this interpretation will be through *laying out* the phenomena of managing risk and patient safety according to the *Dasein* of each participant. Interpretation of the collective *lifeworld's* will be related to key Heideggerian concepts, such *as the* of the *Dasein (*existence*)* of each participant and *temporality* of *Being in the world* alongside *Others* managing risk and patient safety.

November 2017 Drowning…. Saturated… absorbed

I'm literally drowning (in a good way – I think?) in the abundant rich data yielded. Positively overwhelmed but not saturated, absorbed. Beyond immersed, entirely submerged with no notion of surplus data. Endless cycles of interpretive iterations. I am in the circle and at some point, need to climb out and make sense.

Figure 7: Reflexivity Box 4

5.2 *Lifeworld's*

Guided by Van Manen (1997) analysis, *lifeworld* themes were generated for each participant found in appendices 18 to 27. Heidegger (1962, p.106/75) refers to an entity as *coming alive* or *lighting up*. In this case, the entity is not only the participant themselves but also the entity of how risk and patient safety is managed in practice. *Disclosure* of this phenomenon, as to "how-the-worldly-character-announces-itself to each participant" was illuminated through the analysis of the various data sets. The process of *lighting up* may be described as coming back to their *lifeworld's.*

The following section is an interpretation of individual participant *lifeworlds* of managing risk and patient safety. For each participant there is a conceptual diagram representing how their individual themes interrelate with each other. This is followed by an interpretive analysis of each of those themes for remaining true to that individual's *lifeworld* perspective. As an iterative interpretation, it is structured according to the lifeworld themes and not presented chronologically according to the sets of data.

This is followed by an interpretation of all the *lifeworld's* according to the overall themes, presented as a collective *worldhood* of the lived experience of managing patient risk and safety for the ten participants in this study. Interpretation of this *worldhood* is done so though the application of Heideggerian philosophy. Participant interpretations are presented in alphabetical order to demonstrate equal value of descriptions.

Details regarding site and participant demographics can be found in Appendix 15 and 16 respectively. For each participant, the interpretive descriptions are

accompanied by a conceptual framework for a visual understanding of the themes and their interconnections. The conceptual frameworks were iterative in their development and constantly changing and reinterpreted according to phases of analysis. These frameworks are evidence of theme structures. In addition to which, a table of themes and subthemes for each participant, as further evidence, is included in the appendices. An example of specific evidence demonstrating how themes evolved through the three phases of data collection process for Beth can be found in the appendices 17 and 18.

With a vast amount of data, and whilst endeavouring to remain true to the lifeworld as interpreted by each participant, the understanding comes through the terminology which is presented as authentically as possible to the voice of each participant. Below is a key to understanding how and when quotes are used, paraphrased referred to in the text and which source they were taken from. A key to the use of quotations is given in Table 6, below.

Table 6: Key to Transcriptions

"Italics with speech marks" more than one word	Direct Quotation, word or phrase used by the participant
"Italics" single word. No specific participant identifier	Is a word or phrase used by multiple participants
Italics without speech marks	Heideggerian Phrase/term
(DiInt1)	Taken from Di Interview One
(DiInt2)	Taken from Di Interview Two
(DiRef1)	Taken from Di Written Reflection One
(DiRef2)	Taken from Di Written Reflection Two
(DiInt1/2)	Point arose in both Interview One and Two
(DiRef1/2)	Point arose in both Reflection One and Two

5.3 Abigail

Abigail is an experienced ANP who has a background in ED. She has been working at the UCC for the last five years with both clinical and managerial roles.

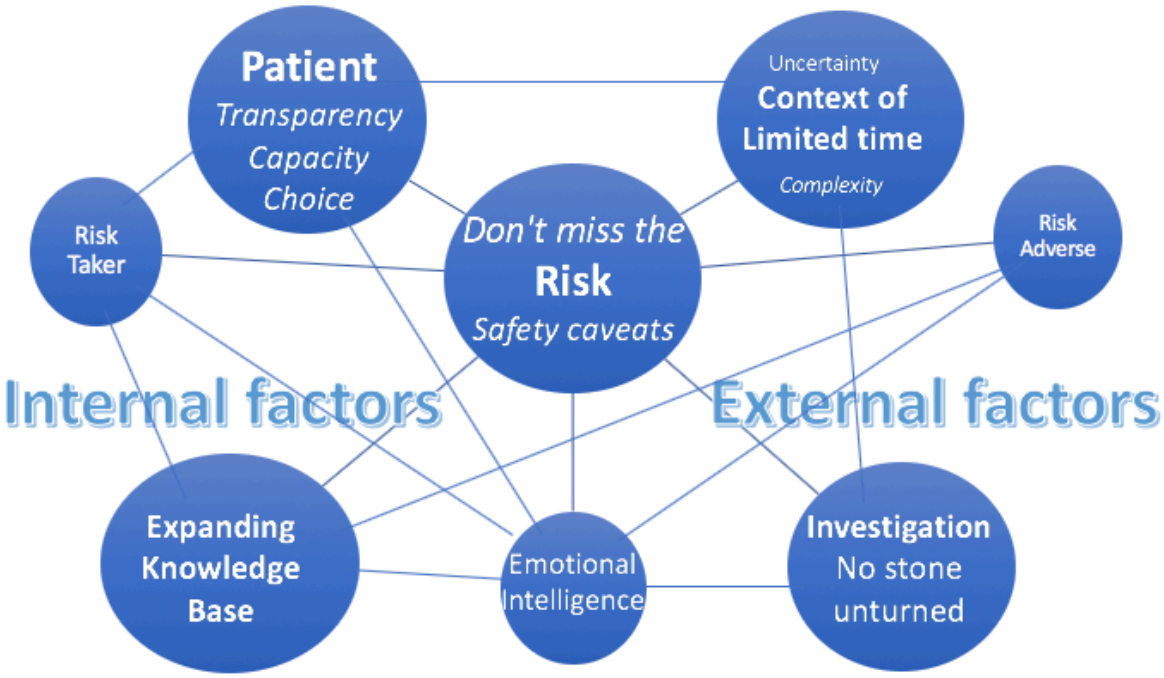


Figure 8: Abigail's Lifeworld (see Appendix 19 for thematic table)

Key for conceptual frameworks:
Large blue circles – main themes; small blue circles – subthemes; blue lines – themes/subtheme links

5.3.1 Context of Time

For Abigail, risk and patient safety needs to be managed within the context of limited time. Abigail describes the pressure to work quickly (AbiInt1/2) undertaking necessary *"short cuts"* of rapid assessments (AbiInt1). She describes subtle intricacies of assessment which cannot be seen by an observer when describing how *"you can give Calpol and do a cranial nerve assessment"* (AbiInt1) simultaneously. This complex multitasking approach to assessment is in contrast to

the isolated focus required when something new or different presents that requires her "*go back to square one, back to basics…start with the theory, what do they know? How do we do this*?" (AbiInt1).

Within this context of limited time, Abigail refers to her responsibility not only to manage risk but to teach and support others to manage and be proactive towards risk which is "*not an easy business*" (AbiInt1). She describes "*sharing the risk*" (AbiInt1/2) and decision-making together with patients and colleagues.

Abigail refers to a holistic perspective that can manifest as perceived inconsistencies within her own practice *"it can look like I'm practising in different ways at different times but it's almost like what's the, you, you, what's that word, you're always thinking about the bigger picture."* (AbiInt2).

5.3.2 Transparency, Capacity, Choice

For Abigail, honesty and admitting to limitations such as *"being able to say to your patient I've no idea what is wrong with you"* (AbiInt1) is an important aspect to managing their risk. Transparency and openness, encompassed with a consideration of patient capacity and choice were core elements to her risk management:

> *In sharing risk with the patient, it is important to consider level of capacity referring to a patient with Down Syndrome although limited capacity… It's about what element of decisions they can make and that's the one thing she could say. She didn't want to go to hospital.* (AbiInt2)

Being open and sharing decision-making with patients was paramount. She endeavoured to be "*really clear about my thought processes*" to patients with

regard to risks and possibilities that have been "*ruled in or out"* (AbiInt1). Caring about how people feel means she is "*very careful"* with her interaction with patients (AbiInt1). Establishing the patient's perception of potential risk, she described as "*getting all the big googlies out and the worries*" (AbiInt1).

5.3.3 Investigation – "Don't leave a stone unturned"

For Abigail, many patient presentations are "barn door" (AbiInt2) for instance "*obvious things that we know that are standards for referral based on national guidance and local practice and local hospital trust guidelines*" (AbiInt2). Other patients present with greater complexity and uncertainty requiring investigation. Abigail describes the "*medical model* "of seeking objective information as a checking process ruling in and out through history taking, red flags and risk factors – "*don't leave a stone unturned*" (AbiInt1). This seeking of information must "*add value to the clinical picture*" (AbiRef1).

> *I like unpicking a story, like an investigation, isn't it? Finding out, finding fact, isn't it? It's satisfying to work out what's going on. Even if you do your best and if you can't, like you can't get, you don't know the final answer you can still go as far as you can. That's interesting...* (AbiRef2)

To be effective, Abigail described employing an iterative questioning style of history taking as "*rolling things in and out"* (AbiInt1), weighing up information and using resources such as people, textbooks and online materials. Abigail refers to the uncertainty due to inherent limited information in her work context, such as access to blood results (AbiInt1), or when a patient has limited capacity (AbiInt2). For Abigail the challenge of making decisions regarding risk was "*confined to what you*

physically see in front of you, your objective findings, and the story you are told" (AbiInt2).

5.3.4 Emotional Intelligence

Whilst reflecting on dealing with risk, Abigail stated "*There's a part of me that's quite scientific, there's part of me that's quite emotional*" (AbiInt1). Referring to a subjective risk assessment she stated: *"My intuition, my experience, my gut-reaction. Heart, soul, you know, just in my being- I thought she's fine"* (AbiInt2).

Abigail described an initial impression: "*You have a quick look at somebody, and you can see how they are physically, how they are emotionally*" (AbiInt2). Abigail wrote of "*seeing"* immediately, "*knowing in the depths of my belly she may die*" (AbiRef2). She referred to intuitive knowing stating that she: "*knew it from the evidence, knew it instinctively …I looked at the knowledge later*" (AbiInt1).

In knowing something, Abigail referred to a "*click*" which was a visual clue that comes from "*seeing the patient*" (AbiInt1/2). She described: *"it's a very big visual clue, it's just seeing a patient and you knowing what they need instantly …and what it is and also picking up signals of how they're feeling all in one moment… If I close my eyes I wouldn't have the same information, its visual"* (AbiInt1).

This "*click"* is then followed by a checking process, the purpose of which is "*just checking you haven't been arrogant, too arrogant to make that decision …*" (AbiInt1). Abigail refers to one's "*ego coming into it… you just show people what you know… I want to get it right".* She discussed the danger of telling patients "*it's*

going to be fine" (AbiInt1) and the importance of empathizing rather than sympathising: *"I haven't got a magic wand – can't fix them*" (AbiInt2).

Emotions can be "*important triggers to alert me into action*" and responding through "*adrenalin and fear*" when a patient is at risk (AbiRef2). Stress allows one *"to think quickly and clearly and allows you to do the job better"* (AbiInt2). She described balancing patients' emotions or worries with her own excitement of thinking "*I've got it - I can do this!*" following a correct diagnosis (AbiInt1) or feeling *"I was back in the groove"* (AbiRef2).

Abigail described a quandary between decisions based on being ruled by the heart or the head. "*Yeah I would have sent her home very happily. ….in my heart I kind of felt I think she's fine. But you never know what you don't know"* (AbiInt2).

5.3.5 Don't Miss the Risk

Abigail seeks to be "*cautious"* (AbiInt1/2) due to worries about missing potential risk or unknown diagnoses. Abigail believed that she *"practice{s} defensively with more insight now that I did before but, erm, there's always stuff you're gonna miss, but you just don't know it yet"* (AbiInt1). Referring to self-doubting her own competence:

> *Am I good enough? Am I going to get this right?... Am I punching above my belt? You know, nurses always have to prove ourselves twice as much, write things down, check things you know, of course we will make mistakes, but you just don't want to when its risk, when there's a risky situation* (AbiInt1).

Abigail sums it up well in the following

> *You have to put yourself central to the experience because if you don't understand what you do and don't know… if you're not cognizant of your anxiety levels or what you're prepared to take on and what you're not prepared to do then… two things can happen, you can be risk averse or you can be risky. So, there's no good being a risk averse practitioner because… people will go to A&E and they'll see their GP and they'll be repeat attenders and then if you're risky, so if you're prepared to be maverick and make decisions that are, are, feel, erm, uncomfortable, then yet again you're putting your own practice and the patient at risk.* (AbiInt1)

In managing risk and safety, evidence of appraisal is imperative regardless if *"the evidence was really strong"* (AbiInt1). With no absolute "*it's about, just recognising what's reasonable and what's okay…. You know, that you can't tick all the boxes…*" She stated that *"mistakes are inevitable"* (AbiInt2). *"I took the risk; we took the risk… it's always a risk, there's always a risk you can get it wrong".* (AbiInt1) Her principles of "*not doing any harm… not neglecting to do something…standing within my scope of practice*" (AbiInt1) help guide these decisions.

5.3.6 Safety Caveats

For Abigail, she supports decisions regarding risk with "*safety caveats"* such as "*plugging the patient into the system*" for example referring patents on to hospital or other professionals, so that she has "*another person to take care of her*" (AbiInt1). Abigail stated that it is "*okay to send every patient with this into A&E",* implying there is a pressure that referring on is not considered "*okay"*. Referring patients on alleviates angst and safeguards the patient as well as her as a practitioner *"at the end of the day I didn't want to be the last person…who'd seen her. I didn't want to take that responsibility*" (AbiInt2).

Abigail says that despite a "*gut-reaction*" (AbiInt2) the patient would be "*okay*" safety -netting is necessary: "*As long as you've got the same safety caveats... So, you still talk to the right people, you make the decision together, you make joint decisions and you, yeah. Keep the patient safe*" (AbiRef1).

5.3.7 Expanding Knowledge: feel your edges

Abigail experiences her knowledge base as *"bits of information you gather with a back door dribbling out old information"* (AbiInt2). The comfort with her knowledge affords her the confidence to be "*emotionally integral"* by never assuming you "*know everything",* which can hinder not only self-development but also the development of others (AbiInt1). Abigail referred to a junior colleague "*bearing witness"* to her navigation of risk as a learning experience for him (AbiInt2). Abigail states "*I like to have a critical eye on my practice*" (AbiRef1).

Some knowledge is more retrievable than others, referring to a memorable patient: "*I'll never forget it the way he presented*" (AbiInt1), particularly when emotive. Abigail identified limitations of a less experienced colleague who, despite being knowledgeable "*what he couldn't do was discriminate the examination finding" (AbiInt1).* Knowledge not only needs to be acquired, retrievable, applied but there also needs to be an active awareness of knowledge that is not there yet. Abigail emphasized how she aims on *"applying what I do know but also being aware of what I don't know …"* (AbiInt1).

5.3.8 Learning: Beyond the comfort Zone:

For Abigail, managing risk can be an "*affirmative"* experience, realising that she is developing and still learning; "*there's still places to go, so it never stops*" (AbiInt1). Referring to a "*glitch*" in which she *missed* a patient's pneumothorax as something to learn from (AbiRef1). The ultimate fear is for a patient to die, "*I haven't lost a patient yet* (died)" (AbiRef1). It is Abigail's belief that *"you can only start advancing in practice if you step out of your comfort zone and experience the next things"* (AbiInt1). When referring to the comfort zone she stated, "*you have to feel your edges*" (AbiInt2). Risk appears to sit beyond the edges of the knowledge comfort zone but awareness and interaction with that edge is where learning and development happens.

5.4 Beth

Beth has worked as a Nurse Practitioner for nearly twenty years. With an ED background she has now worked both as a clinician and manager at a MIU for fifteen years.

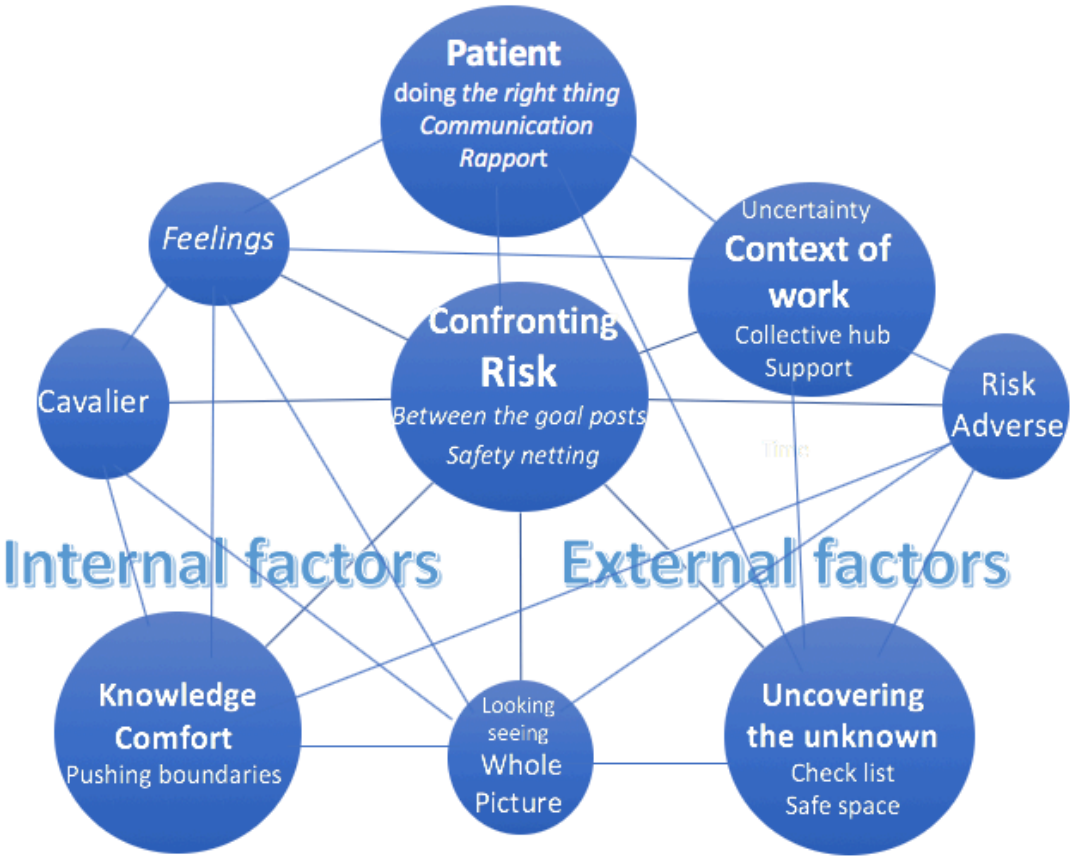


Figure 9: Beth's Lifeworld (see Appendix 18 for thematic table)

5.4.1 Confronting Risk – Between the goal posts

Beth's acceptance of inevitability of risk is clear, she "*takes risks a lot*" (BetInt1) and attributes to her work contextual factors such as long ambulance waits. Increased risk taking has led to increased risk tolerance. Beth refers to a constant "*subconscious"* awareness for potential risk which only on occasions comes into direct consciousness. She described that it is only a "*few times a week*" (BetInt1) when something happens, and she becomes aware of the risk and is "*forced to confront it"* (BetInt1). The significance of that risk is rationalised: "*I knew in my head it didn't make much difference*" (BetInt1). This deliberation is often driven to feelings of worry that she may have "*missed something"* (BetInt1/2). Feelings of

concern are rationalized through the likelihood of probability, "*everyone is allowed it once*" (BetInt2).

Beth used a metaphorical "*goal post"* to illustrate the approach she takes when managing risk. She referred to aiming the football between the two extremes of risk management as "*cavalier"* at one end and the "*incapacity"* of being "*overly risk-adverse"* at the other end (BetInt1). The accuracy is relative to the context of the situation and directly relates to confidence and competence. Returning to the goal post analogy in interview two, uncertainty was referred as a "*wobbly football not aiming straight and ricocheting off the goal post" (BetInt2)*. She described a patient as being "*acute but not too acute…edging into…*" perceived risk and in this case the need to send the patient to hospital in an ambulance (BetInt1). Speculating whether risk taking makes her "*laissez-faire*" or a "*cowboy*", she justified it by saying that decisions are made for individual patients (BetInt1).

5.4.2 Risk - a learning opportunity

In the second interview, Beth deepens her interpretation of the phenomenon of risk and patient safety which she summed up:

> *…it's like competency….managing risk is sometimes like aiming a football through two posts and you're hoping that you're getting it right and you're not going to one extreme or the other, so you're not being risk adverse and you're not being completely sort of um overly cautious, to the point where it incapacitates you, and I think as your practice develops over years, um, you become more comfortable with managing that risk. I think you become more confident about what risk is, that providing that you're safety-netting and that you're explaining to the patient the risk that they're taking in conjunction with you and it's their choice, providing um it's, though not obviously making a completely wrong decision, so that you have to judge their capacity. I think um, I think that's probably how I would articulate it. It*

doesn't feel particularly (chuckling) um, err well put, but it's quite a difficult concept to unpick… (BetInt2)

Thus, Beth experiences risk as an opportunity to develop and advance her practice into new territories of experience that she will then be more comfortable with in the future.

Safety-netting is a coping behaviour of Beth which manages risk for both herself and the patient to safeguard that nothing is missed. Beth senses what is required and is only satisfied once achieved a feeling of "*comfort"* (BetInt1/2). When aiming her football towards the "*red* (meaning risky) *goal post",* there is less comfort or certainty and thus more safety-netting is required, such as referring to other services. She related to the "*titrating of a sliding scale"* to individual situations between being over confident and risk-adverse (BetInt1). Questioning *"am I doing the right thing?"* as part of the process (BetInt2).

Patients' capacity to make "*informed choices"* guides the level *of "safety-netting"*, as it involves a bargaining of "*trust"* that *"strict instructions"* will be followed. This includes "*openness"* with the patient of her own vulnerability, and exposure to professional risk, and that in safety-netting she is also protecting herself.

5.4.3 Rapport

Beth used her rapport with patients to effectively co-manage risk and safety. Through a dynamic interaction, she created a space in which the patient can feel comfortable, "*picking up cues"* through observing body language and listening and determining whether "*cranking up of rapport"* is required (BetInt1/2). Once

rapport was achieved through empathy and respect, she described an *"internal twang", a* "*visible release of tension*" in which the patient is then more at ease or *"comfortable"*" (BetInt1).

> *It's an internal twang (chuckling), um it's, it's, how would I describe? Well, um, it's the, I suppose it's that point where you recognise that they're seeing you as a human being, they're, they're seeing you, so usually it's something in their eye contact or their demeanour which relaxes, it just gives a bit, and you can feel that tension go phew a little bit. So that's how I recognise it I suppose (BetInt1)*

Rapport achieves "*a deep human connection*"" with patients enabling Beth, herself, to feel "*comfortable*" in her management of their risk and safety (BetInt1/2). For Beth, rapport is according to perceived risk, temporal, contextual and potentially lost through poor communication. Retrieval of lost rapport can be restricted by time. Beth also described using coercive behaviours such as "*persuasion*" or "*manipulate*" when she perceives it necessary to protect the patient from harm (BetInt1).

5.4.4 Uncover the Unknown: Seeking information

A feeling that something *"has been missed"* (BetInt1/2) triggered a need for more information. She described this as "*peaking interest"*, being *pulled in, drawn in* and wanting to "*unpick*" or "*uncover*" what is not yet known in order to reveal the "*whole picture"* (BetInt1) and accompanying feelings of *"concern", "discomfort", "fright"* or "*worries"* of something that "*might happen"*. Taking *"a few steps further"* to rule out the "*worst case scenario*" for Beth required good history taking, examination, cue-reading, questioning and understanding the patient's context

(BetInt2). Running through a "*mental check list of 'red flags*" *of potential risks* (BetInt2), Beth judged whether she had achieved sufficient information, within the constraints of her environment, as to how comfortable she felt that nothing had been missed.

Initial assessment was rapid "*as soon as I saw her…I put my hand on her tummy"* (BetInt1), or "*initially it seemed like a straight forward scalp laceration"* (BetInt2). A "*clear picture*" (BetInt2) was experienced when things made sense/added up leading to a feeling of comfort and ease of conscience. Without this clear picture there was an awareness of risk in which uncertainty coupled with concern slowed the judgments requiring action such as seeking information, advice or safeguarding.

5.4.5 Inner Self - Subjective feelings

Subjective feelings were key to Beth's core of this experience of managing risk and patient safety. Seeking "*comfort"* (BetInt1/2Ref1/2), certainty, satisfaction and ultimately giving "*a feeling"* the patient was as safe as they could be was Beth's ultimate goal. Achieving a resolution of negative feelings of "*concern", "worry", "discomfort"* was the aim *(BetInt1/2Ref1/2)*. Beth described being "*dissatisfied" (BetInt2)* if she had not enhanced patient's safety. Stronger feelings of shock, or *feeling awful* can arise from a deep sense of responsibility: "*oh my God – I've let this lady down… Did I miss something?*" (BetInt1). It can be necessary to "*put feelings in a box"* in the face of powerful emotions "*frustration", "annoyance"* to retain objectivity and for judgements not to be "*clouded"* (BetInt1). She referred to

negativity towards patients as having *"an evil twin on (her) shoulder… tempting (her…)"* (BetInt2).

5.4.6 Context of Work

Beth referred to herself as the "*collective hub*" (BetInt2) managing not only her own risks but that of a whole department. Aware of multiple risks, Beth referred to having to "*park"* patients in the waiting room in order to focus on the risk she was being confronted with (BetInt2).

Time was a factor of managing risk and safety, Beth described the benefit of having the time to *"drip-feed information*" (Betint2) to a patient. Risk judgements were affected by time of day, in terms of her own capacity, logistics, accessibility of support from services or colleagues and patient context. This was with regard to how well a parent was able to monitor a child's head injury at night or an elderly patient discharge. Beth referred to *"impossible logistics – 'you need to cut through it all and just get the patient from A to B'"* (BetInt1).

Applying guidelines in the "*reality of practice"* involved "*rather than doing the correct thing, it is about is doing what's right for the patient…within safe parameters, obviously"* (BetInt1). Sometimes doing what is right for the patient may be riskier yet may be considered subjectively by Beth as the "*right"* thing to do. For Beth being effective in management of risk and safety was not "*blindly following the rules*" (BetInt2) rather it is the competent application of the rules to make the right judgment in individual patient situations.

5.4.7 Knowledge Comfort

Beth believed her knowledge base gave her confidence and competence in situations of risk and safety. It afforded her *"comfort"* in measured risk-taking with patients (BetInt1/2). Sensing situations, she subconsciously connected to her knowledge base. Beth referred to the difficulty in objectively rationalizing decisions with a basis in her subjective "*subliminal*" (BetInt1). She speculated that rather than specifics, it was a multiple of factors or a more holistic perception such as "*how the patient looked"* (BetInt2).

Common scenarios that are comfortably within Beth's knowledge afforded rapid decisions *"on the hoof"* (BetInt2) and the confidence to make a "*barn door"* diagnosis with "*eyes shut, and hands tied behind your back"* (BetInt1). The *peaking of interest* (BetInt1) happened when something was not yet known or understood about the patient, therefore not yet part, and thus a gap in her knowledge base.

Beth reflected on why certain patients "*stick out"* (BetInt2) in her memory, speculating that with her deep connection with patients, she saw how the "*world turns for her in that moment",* the impact for her as a practitioner, resulting in an experience that sat more readily available in her knowledge base and one she will "*remember all my life"* (BetInt1) thus suggesting a strong emotional component.

Beth discussed that in the early part of your career, "*erring towards the green goal post of safety"* and being risk adverse tended to be normal but that increasing experiential knowledge in a safe way enabled these junior practitioners to move more "*towards the red post risk taking of centre of the goal" (BetInt2)*. Beth discussed "*creating a space"* for a colleague to learn through them sharing an

experience of managing a patient together involving risk within a safe comfort zone of her experience (BetInt2).

5.5 Catherine

Catherine has been an ENP for eleven years predominantly in ED but currently working at the UCC.

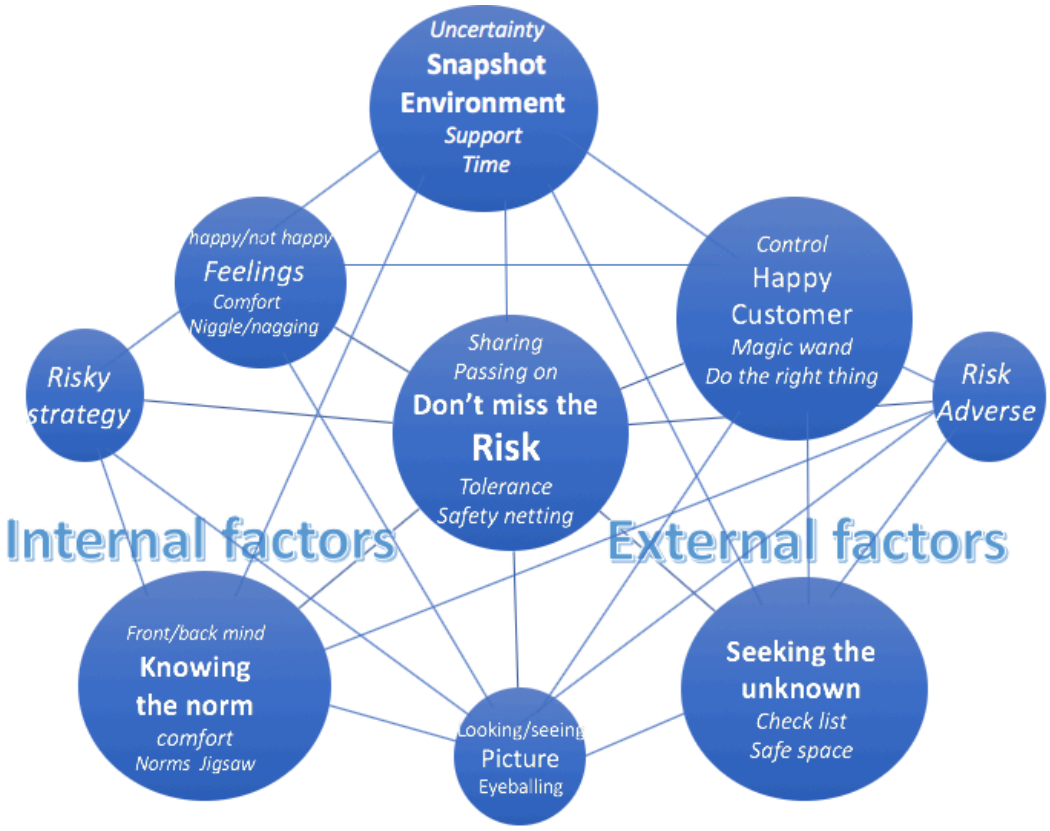


Figure 10: Catherine's Lifeworld (see Appendix 20 for thematic table)

5.5.1 Snapshot Environment

Catherine referred to the limitations of the clinical setting in which unknown patients pass through: *"We see people in snapshot time"* meaning the *"short*

amount of time isn't it really to, erm, make a decision" (CatInt1). Information is limited to isolated moments in time, in contrast to GPs who may have "*multiple snapshots in time*" (CatInt1). Catherine warned that this moment "*is only as good as the point in time you're doing it*", particularly when "*eyeballing the waiting room*" (CatInt2).

This snapshot environment is challenged by uncertainty and complexity. Catherine described how complexity can be sensed within seemingly simple presentations:

> *You know, wound open, stitch it, job done or something like that. It was, it was, you know, am I seeing things here that don't really exist? Am I creating, you know, concerns around this woman ... because maybe you have a certain feeling, you know, am I talking to somebody else and saying I have this little concern which actually you have ... you know.* (CatInt1)

Catherine speculated that her sensing of a situation may overcomplicate and potentially see things that are not there. Her tentative sensing of the situation included questioning hinged on uncertainty.

Catherine discussed guidelines could be "*open to abuse*" if patients have a particular agenda such as wanting a plaster of Paris, attention, or time off work (CatInt2). Value judgements such as these may be made in managing risk.

Referring to uncertainty with regards to a possible child safeguarding incident: "*If you have a definite thing, oh she's, you know, hitting her child you've got obviously a chart... you know you look at the chart, the flow chart for, you know what you do if kind of thing*" (CatInt1). When faced with uncertainty or complexity, for Catherine it became more of a "*personal decision"* (CatInt1) thus one which cannot align with a care pathway.

5.5.2 Don't Miss the Risk

Catherine referred to having to tolerating risk and patient safety *"all the time…on a daily basis"* (CatInt2). For Catherine, risk is *"always on your mind"* (CatInt1). *"There are certain things you don't want to miss"* (CatInt2) such as a potentially critically ill patient. *"Eyeballing people…it's all about prioritizing"* (CatInt2).

Feelings of being "*not happy"* triggered an awareness of potential of risk. These feelings were described as "*there's something strange…there's something else going on here…*" (CatInt1). Catherine speculated that this trigger may be something as subtle as the way a baby smiled at her in a way, she perceived it to be "*drinking up attention*" (CatInt1). Decisions made about risk are dependent on "*risk aversion"* or "*tolerance"*, thus "*the level of risk you are prepared to take*" (CatInt2). Coping with, or reducing risk once it had been identified may take place through "*sharing"* information, and therefore sharing risk with other professionals (CatInt1). Through this, Catherine described a sense of relief, through feeling supported (CatRef1). If you're "*not happy* with the risk, *you pass it on"* (Catint2).

For Catherine, the "*easy thing"* was often not the "*right* thing" to do for the patient: "*the easiest thing is to just plaster it and send it on and then you don't have to worry about it, the risk is no longer yours*" (CatInt2). Catherine chose to take the "*more risky strategy*" (CatInt2) of not following guidelines because "*I just felt that there was something wrong about it, it just didn't feel right*" (CatInt2). Following a "*weighing up"* process Catherine may have been "*happy"* to take the "*risky strategy"*, supported by *"throwing in some safeguarding"* (CatInt2) or *"safety-netting"* (CatInt1), for example, *"call 999 if…"* (CatInt2).

Risk to self not only involved "*upsetting"* experiences such a verbally aggressive patient (CatRef1) but also concerns of professional risk of "*litigation"* (CatInt2). Catherine described being "*anxious for weeks"* about a potential complaint (CatRef1) and discussed the implication of *"If you go, have to go to court you know if you haven't written it in the notes it didn't happen"* (CatInt2).

5.5.3 Happy Customer

Catherine's ethos was that "*You want to leave people feeling like you've helped them*" (CatInt1). "*We are programmed to make them happy*" (CatInt2) to achieve a "*satisfied, happy customer*" (CatInt1) or "*happy clients*" (CatInt1). However, "*managing patient expectations is important*" (CatInt1). She referred to conflict of not having a "*magic wand*" for patients' unrealistic expectations; patients being "*dissatisfied*" (CatInt1) resulting in her own professional "*dissatisfaction"* (CatInt2).

Catherine discussed the challenge of managing safety when health values conflict, patients declaring they "don't *take painkillers in our house"* (CatRef1). She described how she: "*felt bullied… loss of control. I bowed to mothers' demands …I should have put the child's needs before hers*"; similar feelings with a different patient where she felt "*we were failing him*" (CatRef2).

Trust and respect were built through allowing the patient time and space: "*I made her feel she was listened to*" (CatInt1). Without trust, risk can be complex to manage: *"She seemed to know too much about the examination…"* (CatInt2), Catherine sensed she was being manipulated or coerced by the patient. Another occasion describing how "*The mother was articulate and manipulative, and I*

allowed myself to be swayed by her. The situation seemed to have a momentum of its own, which I should have resisted" (CatRef2).

5.5.4 Seeking the unknown

Catherine described seeking information in order to form a picture: *"sharing of information and gives you a picture of this person, doesn't it?"* (CatInt1). Catherine referred to being a "*detective, finding out what is wrong*" (CatInt2), seeking information needed to safely inform decisions needs to be targeted: "*we cannot investigate everything*" thus it needs to be *reasonable* (CatInt2).

Catherine stated, "*for me, it's a major thing to look unwell"* (CatInt2). She described this visual assessment:

> *A big thing of doing the job is you really look at people as they come in. You're making assessments from the minute you see them; you know, how do they look? How are they behaving? How do they come across to you?* (CatInt1).

She described during the consultation: *"actually watching her for a little period of time it became very, erm, aware that she wasn't really reacting to the child very much"* (CatInt1).

For Catherine the idea of *"eyeballing" (CatInt2)* suggested more than just looking. - "*I think you are making judgements and building a picture every second you look at that person*" (CatInt1). Catherine referred to an initial look from which a "*snapshot"* opinion is formed: *"when they jump off the chair and bound towards you… I've already decided I'm not admitting her…."* (CatInt2). *"It leads you down a*

certain path…" (CatInt2). Seeking information was about seeking the unknown: *"It's when you can't find things that the challenge lies, isn't it?"* (CatInt2).

5.5.5 Feelings – not being happy – sensing

Catherine described sensing risk awareness of *a "vague niggle there was something else going on"* (CatInt1) or an unsettling *"nagging little doubt at the back of my mind"* (CatInt1). This sense of "*concern"* or *"discomfort" (CatInt1)* lead to seeking a deeper understanding of a situation and questions to herself: "*Is the child happy with the mother? But he didn't seem unhappy…*" (CatInt1). Catherine explained that when consultations are straight forward… "*A child's got a cut on his leg… then everybody's happy*" (CatInt1). On occasions where the picture did not fit with her concerns, i.e. when what she was seeing and feeling did not align, this triggered a potential for risk.

Being *happy,* or not, was an important element of Catherine's experience of managing risk. Catherine referred a patient "*not being happy"* when care did not meet expectations compounded by a further discontentment from her perspective as a practitioner of "*not being quite happy because I'm thinking oh, you know is something going on here? This isn't quite right*" (CatInt1).

When faced with uncertainty, Catherine referred to an "*enormous responsibility"* (CatInt1), *"just wanting to do the right thing I suppose. You always want to do the right thing, don't you?"* (CatInt1). She was guided by a moral or ethical conscience through sensing "*It's not about you, it's about doing the right thing for the patient*" (CatInt2).

5.5.6 Knowledge - knowing the norm – jigsaw of knowledge

Catherine referred to experiential knowledge that enabled her to identify what was "*normal"*. Catherine felt that of all the presentations she saw: *"89% I know…"* (CatInt1) and things *"add up"* (CatInt2). This is in terms of normal presentation and normal treatment response "*did my usual thing*" (CatInt2). Known patterns of presentation and patterns of response: "*Does that story fit the injury?*" (CatInt1). In applying a situation to her knowledge base, the presentation of the injury did not fit with potential injury: "*Mechanism of injury for a scaphoid is generally a fall on an outstretched hand …and she didn't…*" (CatInt2).

Catherine discussed how she was compelled to deviate from the "*normal thing*" (CatInt2). *"So, I thought oh that's a bit odd…"* (CatInt1) or presents the idea of an "*odd story*", "*just something about her*" (CatInt2).

The risk was about something that was not known: *"perhaps I'm totally wrong in even thinking that there was a problem. It was just ... it is that little bit of sort of, I suppose, you can't put your finger on why you were thinking it but it just ... the whole thing didn't seem quite right."* (CatInt1). It is a sense that is difficult to evidence or rationalize. *"I think at the very back of my mind I slightly thought is there a bit of Munchausen's by proxy going on here"* (CatInt1).

5.5.7 Reflective learning - sleepless nights

Situations concerning risk and safety can precipitate a reflective period: "*I did find myself thinking about it over the next few days"* (CatInt1). Indeed, *"very few people don't finish a shift and think, oh, did I do, should I have done that"* (CatInt2). Taking responsibility for decisions involving risk can lead to burdened feelings of

vulnerability and concern: *"She* [the patient] *goes away and you think later 'why have I exposed myself to risk?'"* (CatInt2).

Reflections involved questioning if anything was omitted or *missed*: "*I wasn't worried because I felt I had done all I could*" (CatInt1). Sharing reflections with colleagues gave Catherine a sense of "*relief"* (RefCat1). Catherine described that as she has gained experience she suffers "*less sleepless nights*" (CatInt1) worrying about patients. However, certain incidents have more impact than others particularly when feelings are involved: "*that touched me quite a lot on a human front*" (CatInt1).

The unknown for Catherine, is that which is unfamiliar; two of her reflections were about children. Bad experiences can lead to: "*a loss of confidence*" (CatInt2) in similar situations. For Catherine, following up on certain patients was necessary "*otherwise they haunt you*" (CatInt1). Catherine stated that having some follow up information on patients may help: "*That would have been the missing piece of the jigsaw, to me would be, you know, what did they think this was? What was happening here?*" (CatInt2). Catherine summed up:

> *If you don't care, if you're not worried, if you don't ever reflect and think back and think, oh, could I have done more or whatever, I mean well that's just not very good. But on the other hand, it's not good if you're, you know, if you become anxious and you're worried all the time about your decisions. I mean that's not healthy either, yeah.* (CatInt2)

5.6 Dave

Dave has been an ANP for seventeen years he has worked for a few years in an MIU and an UCC but has predominantly worked and is currently working in an ED.

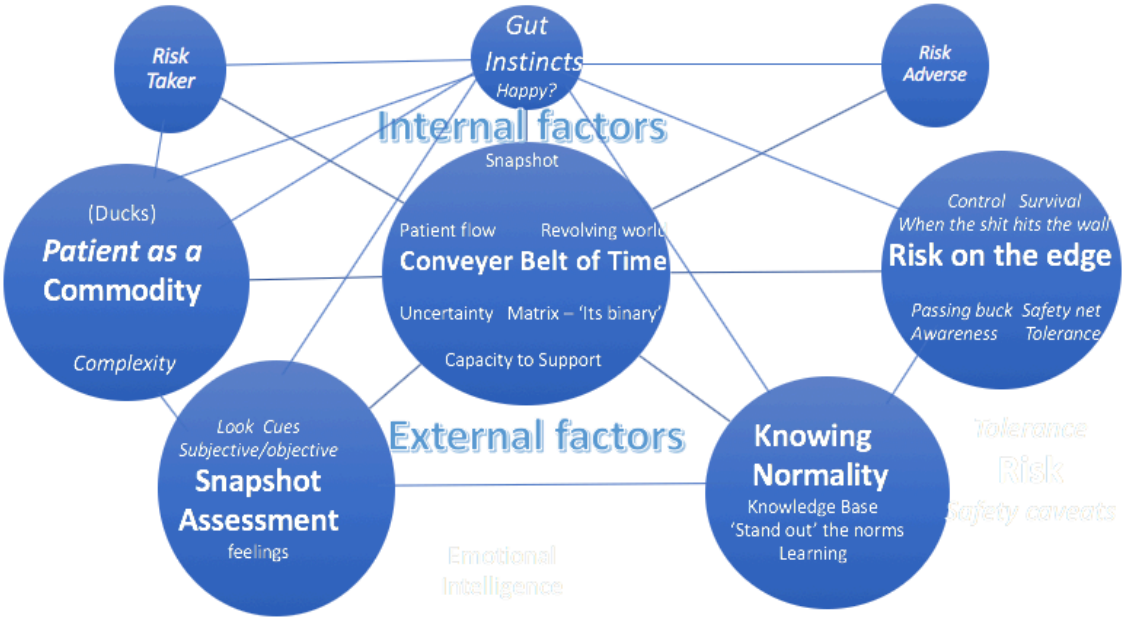


Figure 11: Dave's Lifeworld (see Appendix 21 for thematic table)

5.6.1 "I'm on that Conveyor Belt "- Time

Dave referred to ED as "*chaotic*" (DavRef1) and *"not the most serene place"* (DavInt1) for both patients and staff. Dave described the EDs constant relentless flow of patients as a *conveyer belt*. There was a sense, for Dave, that as an ANP in ED you are part of a bigger machine of which you have little control, time keeps passing and things keep changing (DavInt1).

> *Cos obviously, A&E is, is you don't have patients in for any longer than they have to be um, so it, it, it is the, the world is, is revolving and um, it, it is very much like conveyor belt medicine. So, we see them, and we see a snapshot of their life, and then they're gone, but there's the odd occasion where they, they, they come, come back and make you think.* (DavInt1)

Dave referred to having to make quick assessments *"snapshot"* (DavInt1,2) under conditions of times pressures: *"you know, moving on I'm, I'm, I'm on that conveyor*

belt, right" (DavInt1). He described it as the "*pressure to see the next patient and it's just a continual…there's no let-up, there's no slowing down"* (DavInt2).

Stopping or slowing down the conveyer he attributed to senior management *"they are almost putting blocks to fail in as obstacles…like taking a nurse away. which slows down the whole process"* (DavInt2). The *"conveyer belt"* slows when you: "*get one patient that's complex, everyone else is waiting behind them, there's a bottleneck and I am that bottleneck…its wears you down, its harrowing"* (DavInt2). Indeed, for Dave, an awareness of limited time meant*, "you're working on gut-feelings and, erm, and reactions. Erm, and it does worry me that one day I will miss something important because of the time pressures"* (DavInt2).

Dave also described a *"vulnerability"* (DavRef1) or an unwelcome loneliness with being an experienced ENP: *"Being efficient can mean you are less supported - that's not where I want to be …I feel that I'm left alone" more than others"* (DavInt2). At specific times, such as night shifts there was less support and therefore patient and staff could be *"left kind of in limbo"* (DavInt1). Also, when requests for more support was not *"fruitful"* (DavRef1) and having *"little leverage to get support"* (DavRef1) when the department does not have capacity.

Dave referred to having "*empathy"* for colleagues who were not coping under "*pressures"* of work (DavRef1). However, he also described at times the "*frustration"* of how these same pressures force him to focus in on the patient and thus not being open to see the wider issues of struggling to refer patients on to other services who are "*stretched… I mean I can only worry about my patient and um, it's difficult to see the bigger picture …cos we're not, we're not open to that*" (DavInt1).

Guidelines such as the Mental Health Risk Assessment can support judgments of regarding risk *"the patient was clearly red on the matrix"* (DavInt1), which simplified decision-making: "*it's binary, innit, he's, he's either Red or he isn't Red"* (DavInt1). *However* enforcing guideline adherence as part of his infection control lead role gave rise to conflict. Despite attempts to "*rule with an iron rod*" (DavInt2), he was exasperated by clinical staff: *"ridiculous excuses for why they are not following the hospital policy"* (DavInt2). Stating: "*It's like herding cats*" (DavInt2). Following an incident in which a senior made him feel "*two inches tall*" when he challenged his non-adherence to safety protocol, this resulted in a "*loss of authority and enthusiasm*" for his role (DavInt2).

5.6.2 Patients as a Commodity

Dave felt an emotional attachment to patients was not necessary pre-requisite to managing risk:

> *I've got a job to do, I, there's no point being emotional about it. … not to sound too crude but patients are just there…it's the only way I can have done this job for so long…. without, cracking under the … patients are a commodity, aren't they? … I need to go through patients to get to the end of my day…. I don't really have feelings … emotionally I don't have any attachment to any, any patient." (DavInt1)*.

Nevertheless, relating to a patient personally, and empathy was evident: "*he could have been a friend of mine"* (DavInt1). Indeed, he stated, "*all my patients get 100%"* (DavInt1), with reference to the "*Hippocratic oath …doing no harm*" (DavInt2). Maintaining patient safety is fundamental to the ANP role, "*that's what we do the job for, we need to make sure our patients are safe…. that's the full stop there innit,*

making sure your patients are safe" (DavInt1) rather than being a *"wet squid"* (DavInt2).

5.6.3 Snapshot assessment

Dave "*snapshot"* assessments (DavInt1/2) of patients based on limited time and is

> *…the observation of the patient… their, their clinical signs, um, their demeanour, looking at um, their mental health status…looking at how we perceive their priority… from every step of the way from, from admission, um, via the receptionist who are untrained, but they are our first eyes and ears on, on patients….To the assessment nurse, triage … um, so this is the ideology of a conveyor belt…they're moving through these … gateways, these little bop, bop, you know flippers opening up and pass though there … the milestones of their journey through A&E….until they get to us, our …potentially … short consultation…* (DavInt1).

Illustrating a dehumanizing, mechanical process of the patients on the conveyer belt gateways arriving into the consultation. Dave described the initial assessment and the importance of not making assumptions based on *Others* judgments: *"It's pretty quick, I mean, I tried to be open minded, I read, read notes… try not to assume anything …"* (DavInt1). These *"off the cuff assessment"* (DavInt2) may be compounded by variable coherent history as in elderly, confused or intoxicated patients. Dave explained how he picked up cues *looking* at the patient:

> *You could see he was physically shaking…wide eyes… giving lots of verbal cues, er, non-verbal cues off …he wasn't in a good space….so you pick up on those…his observations, there was nothing that would make me think that it could be something else um, and the, from the organic cause.* (DavInt1).

This looking involved seeing beyond the immediate risk and watching for other potential risks. Dave values visual assessment of risk:

looking at a screen doesn't mean that it's, it's all under control. You need to do; you need to face-to-face… doing regular walk through. …to find out what's going on, to see how people are coping…. it's the non-verbal cues you see when you actually speak to someone. (DaveInt2)

For Dave, he described feelings of risk as "*not being happy*" (DavInt1) or being *"worried"* or something that "*sat on his mind*" (DavInt1). In multiple or high levels of risk *"you gotta go with your instincts"* (DavInt1). Dave referred to a dynamic processing of information which is not reliant on objective information or assessment of others or the but rather it involves *really looking* and subconsciously assessing risk yourself:

You're not conscious of the process… It's, it's happening it's, it's, it's going on…you see a patient in pain, you call the patient, you observe how they stand up…do they grimace when they stand up… or do they skip in because they've forgotten that they've got an ankle injury … you constantly assessing … them… you're looking through the window when you're calling other patients... (DavInt1)

5.6.4 Risk on the edge

There was an underlying acceptance of the pressures of risk and the necessity to cope: "*I just grew a pair and cracked on*" (DavRef1) and that often the "*best solution is not possible*" (DavRef1). Coping with this risk at critical times, Dave referred to as *"survival"* (DavInt2), he referred to "*when the shit hits the wall*" or:

when the wheels come off…you go into shock isn't it? ...it's only the central organs working but …, your level of … intuition?... is, is what you rely on… instinct is all you've got ". At this level he describes *"a fight or flight… you're working on non-verbal cues … you know and you, you're bringing other people in to observe we use other skills… if there's somebody we're worried*

about, we'd, we mention can you keep an eye on that one… and flag it up. (DavInt1)

In this environment of limited control and a high degree of uncertainty, Dave believed that a *"slice of luck"* (DavRef1) was a factor in avoiding a *"near miss"* (DavRef1). After a shift of high stress, Dave described feeling *"physically and mentally drained"* (DavRef1). At such times to protect both himself and patients, he was guided by instincts:

…it's a survival thing, because the one thing that we do, we wanna keep patients safe … we wanna keep ourselves safe, you know, we wanna keep the environment safe… Um, whether that's from patients assaulting other patients, or ah, vulnerable people being put in the wrong you know, area where, where they, they are potentially at risk. (DavInt2)

Dave discussed the challenges when agendas from different professionals do not "*cross-fertilise*" (DavInt2) and you have a "*clash of agendas*" (DavInt2). Discussing this conflict: "*You've got patients' expectations and mine don't always meet…, speciality expectations don't always meet, but you do what you deem is safe."* (DavInt1)

*A*t times of stress, managing risk can be a "*flash point for friction and conflict*" with colleagues (DavInt1). Safety-netting can be achieved through "*sharing"* (DavInt1/2Ref1) or passing risk to others. He discussed how this is facilitated by having good relationships with senior doctors in the ED who are a good support and educational for ANP development. When feeling like he has "*taken the patient as far as I can….*", Dave referred the relief of referring patients on to others:

A little bit of weight of, um, I mean it, it, it's almost like you, not passing the buck, but you're it, it's we, we deem it as safety- netting… so now it's

somebody else's problem. Er, but that, that essentially is, is it, isn't it? I'm protecting myself … by protecting the patient…. (DavInt1)

Risk was constantly assessed throughout a patient's journey in ED risk and either "*flagged*" and "*prioritized"* or potentially missed: "*the risk assessment starts at, at um, triage, um, they ca… they can um, increase their priority. Um, this guy he hadn't been flagged up as er, um, as a patient in crisis* …" (DavInt1). Dave had a constant awareness of wider risk outside the immediate: "*I was unable to keep an eye on any of the other patients*" (DavRef1). Continuous gauging of his risk tolerance capacity was necessary *"we choose to level our safe practice, it changes when, when the pressures are up… Which is, is always a concern for me, because that's the time when mistakes happen" (DavInt1).* Dave described being guided by an inner conscience*: "Cos at the end of the day, I mean there's … if I was doing things that were unsafe I'd, I'd wanna check myself in the mirror a bit and say, 'what are you doing?'"* (DavInt1).

Dave attributed that it is experience and working under stress that affords him such instincts.

So, it's about safety-netting (pause) doing, I mean that … I possibly that's when you rely on your instincts more. But how do you document that, I don't know. (DavInt1)

I've been in the game a while you know, so you do, you do pick up sort of an intuitive response to things. (DavInt2)

Despite the challenges of managing risk, Dave referred to other less clinical parts of the job as "*dull*" and infers a certain relish in "*life on the edge*" (DavInt1). He discusses "*liking the buzz…the pressure"* (DavInt2), referring to a "*white knuckle*

ride" (DavInt2), recognizing that he chose to work in a pressured environment but there's "*got to be a point where that pressure stops becoming fun"* (DavInt2). This is about a perceived sense of control, recognizing that *"times it's not, it's spiralling out of control and there's only me in there. …(Laughs). And I don't really fancy being in front of the NMC explaining why I've done something… that worries me"* (DavInt2).

5.6.5 Knowing Normality

Dave's experience and knowledge base affords him a perspective on what is perceived to be the norm with regard to a typical familiar patient presentation. Anything that stands outside of this norm can highlight potential risk. When a patient did not respond as expected, "*… it, it didn't, it didn't tick the box of, of the normality of … of patients"* (DavInt1), it alerted for a potential risk**,** as he describes:

> *you're looking for the one that is really unwell … they stand out … into a sea of people…I don't know… Spooky… I've got skills… they might be the one that isn't making all the noise, it might be the one that's just slumped in the corner that…I dunno…you're usually on the Money…You'd still be looking at everyone else in the room. It is beyond there, innit, so I don't know….is it looking or observing? I think it's…another it's next level of sight isn't it.* (DavInt1)

Dave referred to a feeling of not being happy when the knowledge wasn't there and where there is a need for him to learn something. He described the few patients that stand outside of what is normal for him, that he is not *"happy"* about, or leads to questioning:

> *There's few patients that stand out … um, yes I do, um, you know, I, I … patients with x-rays that I wasn't happy, or I was questioning from a personal*

learning point of view, from a patient's safety point of view, from, from you know, from a… (DavInt2)

These "*stand out patients*" represent a learning need or indeed an opportunity to learn. Whilst Dave described keeping patients safe as fundamental to his role or as a:

"*full stop*…then *you've got to have brackets…you've got to keep your practitioners healthy and happy, because otherwise who is going to see the patients…you've got to invest in your workforce…whether that's educationally or support..."* (DavInt2)

Previous experience also affords the necessary confidence to cope: "*My confidence in my own ability was important as I have been in this place before and no one has lost an eye, so to speak*" (DavRef1).

5.7 Di

Di is an experienced ANP with a managerial component to her role working across the semi-rural MIUs. After a long nursing career, she is approaching retirement.

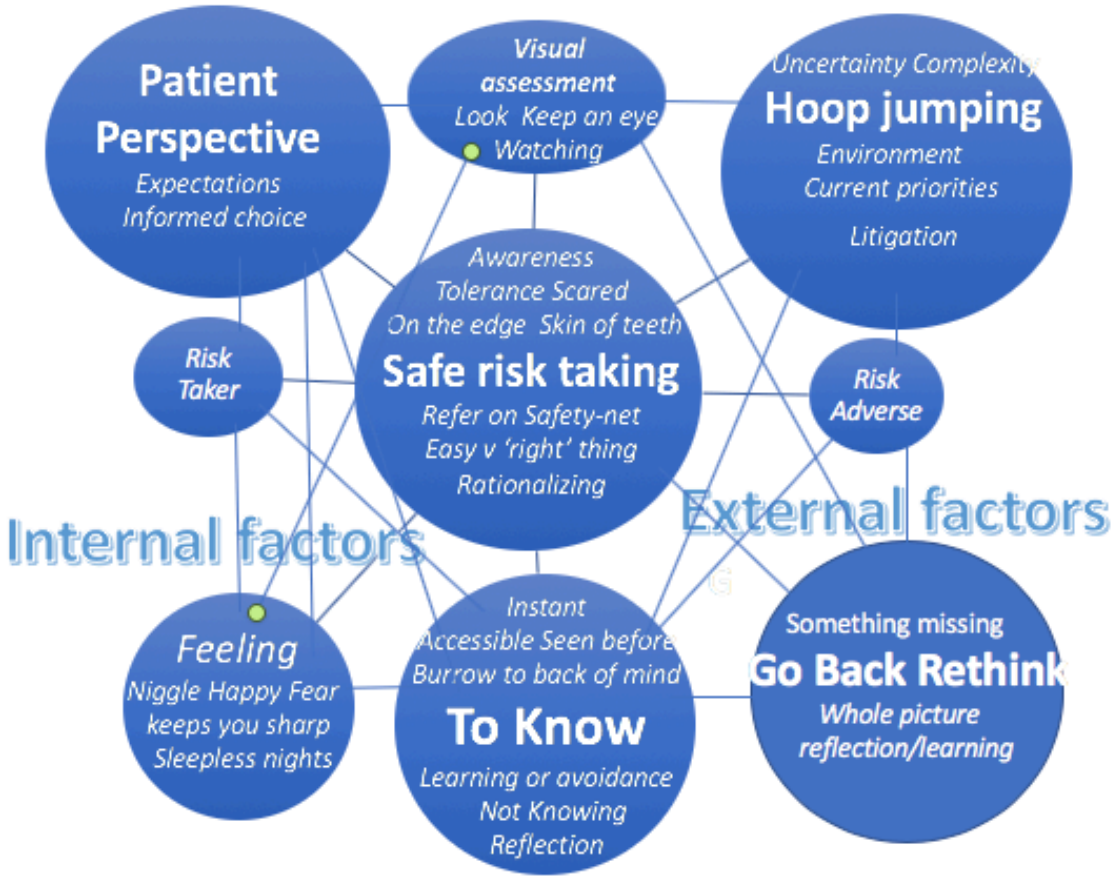


Figure 12: Di's Lifeworld (see Appendix 22 for thematic table)

5.7.1 Hoop Jumping - Context of ANPs

As an ANP, Di felt she has had to "*jump through hoops…to work really hard to be accepted by people*" (DiInt1) because she is not a doctor. Describing what influences her practice around risk she stated:

> *There's lots of drivers from that on, there are national drivers, there's A&E drivers, there's our own um, ethos is that, um, not in a bad way, but you know, yeah, and what we should be striving for is to be good enough to make appropriate decisions about these patients.* (DiInt1)

One of these drivers was avoiding hospital admittance: *"what we want to do, is do complete episodes of care. That's best for the patient if you can manage that safely"* (DiInt1). *"There are some people who do have to be admitted …"* (DiInt1)

Di stated, "*when you get a really good nurse practitioner, they take risks and are not risk adverse, but they make a much more holistic assessment*" and differentiates from Doctors whom she describes as risk takers who can be "*gung-ho*" (DiInt1).

5.7.2 Patient Perspective – informed choice

For Di, informed choice is managing risk and safety is key. Di states*:*

> *These people can make a decision. It's not always a good decision…And actually ...That is okay if they're making the decision from a place of, you know, knowing all the facts"* (DiInt2); *as long you're really clear about what your concerns are, and that you mitigate them as much as you're able."* (DiInt1)

As an ANP, Di explained*: "we are much more aware now that patients' wishes, you know, have to be taken into account, if they are you know, um, what's the word I'm looking for, if they are you know, um, have capacity…* (DiInt1). *"So, you give them the facts, you give them the facts, you know, 'actually yeah, you, you possible could go home, but I'm worried about these things, you know you're likely to fall again, because of X, Y and Z" (*DiInt1). Di had seen a change in this approach: *"this is how I would want to be treated as an adult with, you know, perfectly able to make decisions. You can't ...we are no longer paternalistic"* (DiInt2) and it is about being *"confident"* enough to *"allow"* a patient to have an "*informed choice"* (DiRef2). There can be conflicting perspectives: "*somebody can be anxious with the…sort of*

*you know, paper-cut can't they?" (*DiInt1). She refers to potential conflict and *despair* (DiRef1) when patients' expectations don't always "*correlate" (*DiInt1).

5.7.3 Safe risk-taking

Di stated *"you couldn't do the job if you don't take a risk* (DiInt1); *"we have to be risk takers… but you have to do that as safely as you can"* (DiInt1) which is sometimes *"by the skin of your teeth"* (DiInt1). Risk awareness and fear is a necessary element: "*everybody should be a bit scared, that's okay, cos that keeps you sharp and that's okay. And you can have the occasional sleepless night, but it shouldn't be every night, cos if it is every night then you can't do the job really*" *(*DiInt1).

Risk awareness might be: *"you need to be aware of who's, who's in the queue…" (*DiInt1). Taking a visual assessment: *"keep an eye on the screen….and a do walk through the waiting room….you cast your eye about, don't you? and keep an eye…"* (DiInt1).

Risk can be a *"niggle"* saying*, "You know this, you know this...you've done this before. You've seen this before or something similar…and um, and you sort of then have to...I'm almost doing it now; you have to sort of burrow back into your mind"* (DiInt2).

Risk can be identified more strongly following a bad experience: *"every time, yeah, I see, you know, kids with, er, short of breath or asthma I think, 'Oh God'"* (DiInt2). This fear can lead to avoidance*: "it's really put me off going there and I really avoid it"* because of the fear of her capability to deal with the potential of what might happen*.*

When risk is identified, the intervention may or may not move the feeling from being concerned to feeling *"happy" (*DiInt1/2). If still not "*happy",* this may lead to referring the patient on: *"I still wasn't happy about him and so I thought, 'Do I want to send him in somewhere?'" (DiInt2).*

> *Sometimes think, we, as a group (ANPs), share the risk cos it makes our lives a little bit easier and you, we feel a bit less anxious, but actually it's not always the right thing" (DiInt1).* The sense of doing the right thing is important and discusses how having referred a patient onto a GP *"He just did the easy thing. (Laughs.) Not the right thing.* (DiInt1)

Whilst referring on may ease a burden, it may not be in the patient's best interests. Di reflects*: "sometimes I think we do (pause) try and pass the risk to somebody else…I think there's a real temptation to not carry that risk yourself…And actually, I think that can stifle your practice* (DiInt1).

Safety-netting was a consistent theme when sending patients home: "*if you…get these other symptoms, na, na, then you have to ring 999"* (DiInt1). "*According to circumstance you may broaden your net."* (DiInt1) Di says:

> *There's nothing more frustrating than people who admit people unnecessarily or send them somewhere else they don't need to go… it's not good for the patient, and…doesn't make the service look very good, you may as well not be there, cos you're just signposting people, aren't you? Um, whereas if you're at the other end um, people don't (pause) aren't thorough, or don't um, just make an assumption that they know…everything. Then they will let something slip through the net.* (DiInt1)

> *…so the person who is good at this, is a person who can take the risks with measured risks, so they can see that in all probability this person, the probability is that they're gonna be okay…* (DilInt2)

Risk tolerance is enabled if she feels:

confident and competent in your examination, in your decision-making…given them the right advice…As you long as you can give rationale as to why you made that decision, and you've safety-netted them appropriately, if they've ignored that or done something entirely different, or whatever it is, then I'm, I feel comfortable with that... If then the patient has come to some harm...there is a limit, you know, people have to be given a certain amount of autonomy over themselves, don't they? And so I can sort of live with that" (DiInt2).

Di described a level of acceptance of patient informed risk-taking.

5.7.4 Go Back, Rethink

Di warned against initial impressions: *"just cos they look fine, doesn't mean they always are fine, and just cos they look really ill, doesn't mean they're always really ill"* (DiInt2). Di describes: *"when it's not what you expect, then you have to go back and re-think it" (*DiInt1). *"I re-examined his shoulder because I think that's what I would always do…go back and look at, try and pinpoint the pain better…"* (DiInt1); "*…you don't wanna miss anything…So now I've got to go down other lines and find out what it is" (*DiInt1).

5.7.5 Visual Cues: *"You've got to take the whole picture"* (DiInt1).

In managing risk and patient safety, Di referred to picking up visual cues *"I like watching somebody walk in…because I can see loads and loads of information" (*DiInt1). Stating, "*It's not just looking. So, it, it's about it's not even having a*

*conversation with somebody, so it's you looking…but thinking of all the things you're looking for, isn't it?" (*DiInt1). Di emphasised the importance holistic perspective, *"You've got to take the whole picture"* (DiInt1) but also

> *People tell you what they think you want to know, which isn't always what you want to know. So, I think there's also an art in, you know, bringing them back to what you want to know, what they're...not what they want to tell you.* (DiInt2).

Di discussed gut-instincts:

> *I don't know that I really believe in gut-instinct and…because I believe that you know all these things…but very, very hidden things… because you've remembered them for so long and, um, so while I will say, you know, I just had an instinct about this person. You didn't really…what you had was picking up all those things that you know* (DiInt1).

For Di, it was the *"niggle"* or the *"gut-instinct, that's what it is. It isn't about, um, having some ethereal, you know [inhale], um, vocational something. It's...but you do have the knowledge but sometimes things trigger it, don't they?"* (DiInt2).

Despite knowledge of what to expect, there was also an acceptance of different levels of risk and uncertainty:

> *With a lot of patients, yeah, there's a certain amount of uncertainty, but it's not unsafe uncertainty, cos actually the, the outcome isn't gonna be that bad, even if it's not right. So, you miss a fracture, but you put in a splint, ah, there we are, so what? (*DiInt1).

Di explained how fear is part of managing risk and patient safety:

> *I do think you need to have a little bit of (pause), I don't know what the word is really, anxiousness, fear (talking quietly) …a little bit of not always being entirely sure…there are patients who really sit on the edge (laughs)… and*

they're the ones who are difficult…and are waiting and are frightening, yeah. Of…so the edge is, do I send them home, don't I send them home? (DiInt1)

5.7.6 To Know or Not to Know

Di stated: *"I have got years and years of experience. So, there's loads of stuff sitting* [laughing] *in my head… some of it is lost forever"* (DiInt2). She described having a "*baseline*…*you will deal with a certain amount of stuff" (*DiInt1). With familiarity comes pattern recognition: *"it's just this sort of niggle and it says, "I've seen this before. I know about this. I know I know this"* (DiInt2) *and "If you've seen something before you know wha… how that might turn out." (*DiInt1). *She states, "the more times you see something, the more you retain it, don't you?"* (DiInt2).

When something is outside of that knowledge or experience, this may lead to concern "*for some unknown reason I was quite panicked by this presentation'*. Managing risk involved recognizing one's own limitations, on describing an area of practice outside of her sphere: *"we all have a bag and that's not mine"* (DiInt2).

Di differentiated between knowledge and awareness: "*I already know about distracting injuries, but you just have to be aware of distracting injuries". (DiInt1).* Whilst some knowledge is *"lost forever"* (DiInt2), other knowledge is more readily accessible: *"So that really sticks in your mind then. And then I have seen it a couple of times since and I instantly know…"* (DiInt2).

Describing looking and then *seeing*: *"just from looking at him you can see; you could see he wasn't okay. So, um ... and then it was a bit more than just a, a normal thing really* (DiInt2). For Di explained *"You get cues from patients and that's what rings in your head"* (DiInt2)." A sense of something unknown or uncertain leads to deeper searching:

> [I] *try and think more about what is causing that. And then because it didn't really tell me anything, then I said, 'so, did you do anything else?' And then when he said he'd got this bruising on his torso, then I looked at that and that's what made me lay him down and then that's when… it all became clear…*(DiInt1)

In this case, it did not fit the initial picture, further information seeking, further examination ... until "*click"* it fell into place:

> *he quite a rigid abdomen (laughs) and he had bruising and stuff, and obviously, then I clicked that he was a spleen … it doesn't haunt me at all, it's not that but I always think about is the fact that I could really have just sent him home. (*DiInt1)

She depicts moments of understanding or insight as a *click*: *"it wasn't dramatic… it was my experience… it all sort of clicked in"* (DiInt1). She describes feeling pleased *"that it all came back to me"* (DiInt1). The click is a strong feeling of knowing or enlightenment: *"It's like the light switched on"* (DiInt2).

5.7.7 Reflection and Learning

Reflecting after incidents of managing risk can involve worrying: *"I didn't sleep all night. [Exhale] I thought I should have just done that. Why didn't I just do that?"* (DiInt2). Di stated reflection as being *"an important part of managing risk, because if you don't keep learning then you, you will either be really risk averse… or you'll be dodgy. To my two ends again"* (DiInt1). This anxious reflection is described: *"you do come in the next day and think, please make, please you know that person's okay, and you check, and you might have had a sleepless night…"* (DiInt1).

For Di, the learning opportunities from experiences of risk were fundamental to safe practice *"you will be a better risk-taker, so make safe decisions, if you keep learning … and if you recognise the times that you didn't do it quite right" (*DiInt1). Learning from mistakes or "*near misses"* is key. Di's opinion was *"if you say you don't need to learn anything then you're not a safe practitioner*" (DiInt1). Reflection has several benefits: *"a) it debriefs you and b) you're sharing something with other people and they're learning something… It also provides reassurance of doing the right thing"* (DiInt1). It was about being *"open to the fact that you'll still learn something…" (DiInt2)*. Once qualified, the learning should not stop: *"that journey never stops*" *(*DiInt1). Di warns of complacency:

> *I think if people are very confident, and complacent in their practice, then they will miss something. And, …people who go the other way, and they're too risk averse. So, either people just admit everybody, because actually then they're never gonna be unsafe. Or …people who are too gung-ho and they just think they know everything …I have been doing it for a long time, but I can learn something nearly every day. (*DiInt1)

5.8 Kinsale

Kinsale is ten years' post ENP qualification. She had three years experience working in a Walk in Centre, seven years in a paediatric ED and two years at her current setting an UCC.

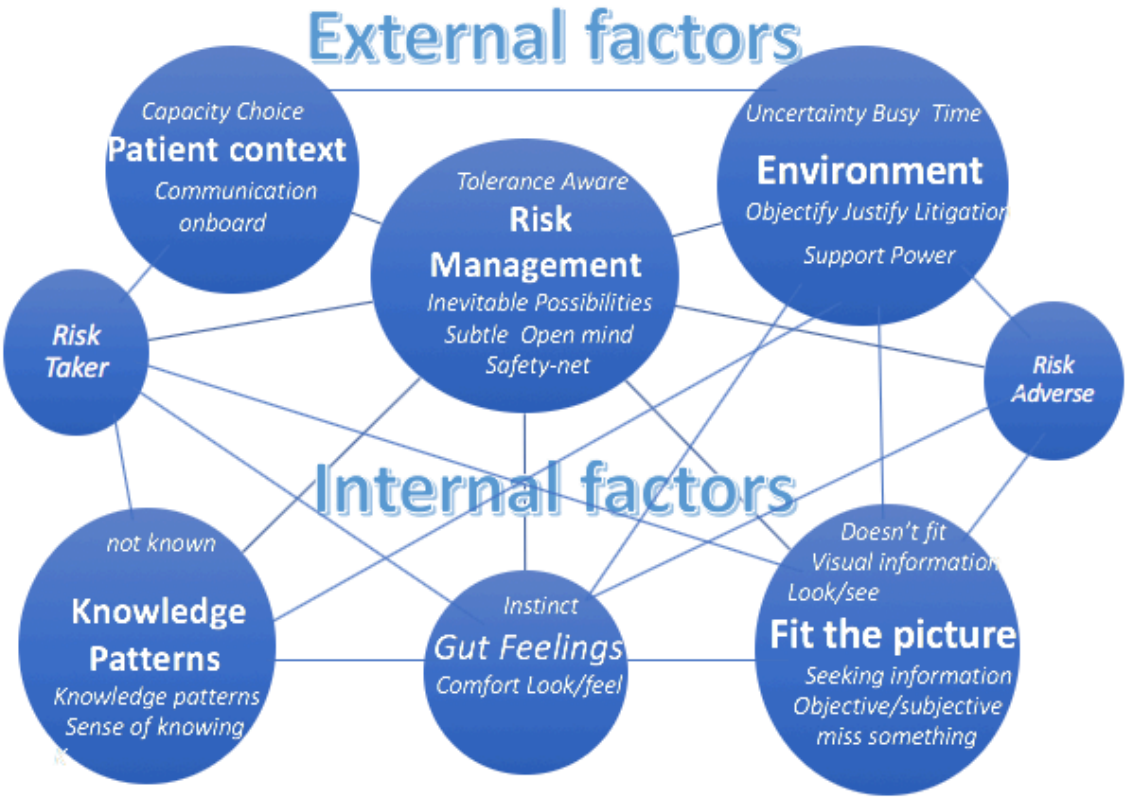


Figure 13: Kinsale's Lifeworld (see Appendix 23 for thematic table)

5.8.1 Environmental factors

For Kinsale, environmental factors impact patient safety "*There were no overwhelming negative factors, as the department was quiet, and I had access to a reporting radiographer that day so, if anything, these factors made the outcome of this case optimal allowing good quality of care"* (KinRef1). In contrast to this: *"This was on a very busy day and to actively observe the patient in the unit also added to the clinical pressure, however in this instance I was not willing for this to interfere with my management of this patient"* (KinRef2*).*

Decisions made regarding risk need to be rationalized and justified: "*I was aware that I would need to be able to justify a decision to send this patient home and this judgement was based on normal vital signs*" (KinRef2).

Kinsale spoke of the reassurance of consultant clinical support for ANPs in ED, such as "*checking"* "*reasonable" to* carrying out blood tests (KinInt1). For instance, "*I discussed him with a consultant but nobody else had examined him*" (KinInt1), inferring an unease that whilst the discussion with a senior aided her decision-making, the fact that she was the sole person to examine the patient meant she was not wholly reassured, and the risk remained with her.

Kinsale referred informed shared decision making *"I explored treatment options with the patient"* (KinRef2). This included consideration of expectations and the wider patient context: "*with that in mind, actually it was just before Christmas… so I agreed with erm, with mum that they could go home*" (KinInt1).

5.8.2 Risk Management

For Kinsale, managing risk and supporting others was integral to her practice:

> *It's something we do every single day and it is part of my daily practice and not just my risk management clinically and decision making but also helping other people around decision making and managing risk within their practice.* (KinInt2)

Detecting risk can be subtle: *"he just looked, he looked slightly more unwell than your average child that presents with a…you-know…an irritable hip"* (KinInt2). Kinsale spoke of being praised:

> *they said well done for picking it up and I was mortified, and I said to the surgeon, but I sent him home yesterday, I didn't…You know, and he said no it's still a good spot because if you'd have not safety-netted properly…*(KinInt1).

The risk of discharging patients' home was managed with a "*very clear safety-netting advice"* (KinRef2); "*…if anything goes wrong then this is the place where you need to go*" (KinInt1). Without safety-netting, something may have been *missed*.

Kinsale discussed conflicting perceptions of risk for example getting a patient's father "*onboard*" through "*careful explaining*", *"reassurance", "relationship building"* in order to achieve a *"professional confidence and trust in my diagnostic skills"* (KinRef1). Risk tolerance can be a factor when doing the *right thing* in the best interests of the patient is of higher risk to the practitioner: *"The easier option for me would have been to admit her."* (KinRef2). These difficult decisions are made based on shared understanding, capacity and trust:

> *My judgment to send her home was also based on the ability to manage the risk associated with this and this included that she had attended with mum who has listened to all my advice and rationale for discharge, mum had capacity* (KinRef2).

5.8.3 Seeking Information to Fit the Picture

Information seeking is a process of revealing and excluding risk potentials: *"there was a possibility of a small unseen fracture"* (KinRef1). Being open to possibilities is an attempt to not allow things to be *missed*.

If a clinical picture does not fit with what is known, the need for more information is triggered, such as further tests "*we did blood tests on him because he didn't quite fit the picture*" (KinInt1) or re-examination to confirm working

diagnosis*: "I examined her left upper limb to confirm that there was no evidence of swelling or bony tenderness – which was to be expected if my diagnosis was correct"* (KinInt2).

When a result from an x-ray was not what was expected or "*did not typically fit the assumed diagnosis*" (KinRef1), further images were taken (KinRef1). Kinsale referred to the X-ray as an *"exclusion tool which allows me to justify and feel more comfortable when taking a more forceful approach at attempted reduction"* (KinRef1).

Kinsale referred to the *first look* at a patient**:**

> *Just looking at…* [a patient] *that first two…what they look like…gives you a lot of information… Yeah I think it is a visual thing, so just sort of how comfortable somebody looks…what their pain level might be, whether they're well perfused, …Other bits of it that you probably are less tangible in terms of describing… It's just a feel for how somebody comes, how somebody presents themselves when they… it's probably more what they look like than what they say… you really do use just what's in front of you in terms of eyes.* (KinInt2)

A sense of "*immediate knowing"* can be derived from this initial look. Kinsale described how she could see*:*

> *just by the way he was lying on the bed I knew immediately that it wasn't his hip at all, erm, and when I, went I went to palpate his abdomen he had a rigid abdomen, so he turned out to be a perforated, erm, appendix* (KinInt1).

"Looking" can be passive or subtle in terms of standing back and "*watching"* can achieve more information and potentially fill the gaps of what is not known. Kinsale described how she *"watched her play with a toy, she was reaching and*

playing with the arm intermittently but still not fully pronating/supinating" (KinRef1). The *"look"* can be quite a powerful informing factor of decisions based on risk particularly when there is uncertainty. Kinsale highly valued the *"look"* of consultants to who, rather than getting verbal advice she asked, *"can you come and look and see what you think"* (KinInt1).

This "*look"* could reassure her of the safety of a patient discharge: *"she looked unwell based on the fact that she appeared pale, however her vital signs were remarkably un-concerning"* (KinRef2). This assessment of *"looking"* enabled Kinsale to feel *"comfortable"* enough (KinRef2) to send the patient home.

5.8.4 Gut-Instinct/Feeling/What did I Miss?

Kinsale referred to being guided by a "*gut-instinct": "It's being aware of that gut-instinct and giving it as much weight potentially as those, as those other sort of more, erm, subjective findings I suppose"* (KinInt2). Kinsale describes this *gut-instinct:*

> *My gut-feeling was that this was high risk and a failed discharge home was quite likely and if I was to give this option, I would have to manage the risk associated with it. At the same time, I wanted to do what was most acceptable for the patient and she was very keen to be treated at home if at all possible* (KinRef2).

Referring to a checking process: *"I think sometimes we go through a process of ticking boxes, almost thinking well I've done that, I've done the bloods, I've spoken to a senior and actually you can override your gut-instinct"* (KinInt2).

Kinsale described a "*clouding of judgement"* by seeing what you want to see and missing *the "true picture"* (KinInt2), she says, *"But it's easy to talk yourself into*

the fact that it's maybe a big effusion and that's why he's not walking…So, then he started to fit the more normal picture" (KinInt2).

5.8.5 Patterns of Knowledge

Kinsale infers an underpinning knowledge of familiarity: *"this was just part of the illness process"* (KinInt1). This knowledge base subconsciously interacts with experiences detecting the norm: "*blood work was all normal…. nothing that really sort of stuck out in terms of that this was a septic joint*." (KinInt1). Decisions are:

> *based on very simple pattern recognition and those that then actually fall out of the pattern and by which we switch our mode of decision-making and think a bit more deeply about what it is that we're doing and a bit more carefully…more careful decision-making is required, as the situation no longer fits the usual pattern"* (KinRef1).

Conscious awareness arises out of situations where what is being experienced triggers concern when the picture that's presented does not conform with expected or known pattern *"he didn't quite fit that picture*" (KinInt2). For Kinsale, on these occasions "*I move from a simple diagnosis based on history and pattern recognition (successful reduction on first attempt) to a diagnosis by exclusion (when things don't go to plan or as expected)"* (KinRef1).

Whilst this insight helps to recognize, understand and manage risk, it can lead to assumptions: *"commonly seen presentation in paediatrics and in most cases can be dealt with quickly without the need for imaging; this pre-assumption affects decision-making"* (KinInt2).

Kinsale described how she *"maybe sort of side-lined, or side tracked"* (KinInt1) by a provisional diagnosis made by a GP and this perhaps led her not to see other potential diagnosis though bias: *"it was just about being railroaded I*

suppose, going down one route and not thinking laterally about the possibilities of another diagnosis" (KinInt2). Kinsale reflected on how an "*open mind*" may afford detecting risk that otherwise may be *missed* (KinRef2).

Indeed, in order to manage risk and enhance safety, Kinsale referred to:

> *trying to move away from those sorts of quick decisions that we make about entire patient episodes, based on pattern recognition. Sort of I suppose doubling back and checking that you've thought about the things that could be, that might need a bit more thought* (KinInt2).

Whilst quick decisions may be made at the front of the mind, Kinsale referred to the "*back of her mind"* as pondering risk potentials: *"So there was a thought in the back of my mind that you know it could still be an early septic joint and that actually he might be more unwell the next day"* (KinInt1)

Learning from experiences of managing risk has changed her practice. Kinsale referred to being *"fastidious"* (KinInt1) about certain areas on her practice following experiences of risk in which near-misses or mistakes have been made.

Driven by a reflective conscience that she may have done something wrong or missed something, she described (you): *"start to feel those sorts of feelings of sort of like guilt in terms of, "Oh gosh what did I miss?"* (KinInt1) and this leads to questioning: *"why didn't I spot this yesterday?"* (KinInt1). These feelings lead to a necessary reflection, pondering thoughts such as: "*maybe I just thought or knew that things might get worse for them, or might get worse for him"* (KinInt2).

She inferred a reluctance or fear to return to a patient whom she felt she may have missed something previously. Encouragement from a consultant: *"No, get back in there and lay hands on that child", erm, he said, 'You saw him*

yesterday, you'll spot the difference and what's going on'" (KinInt1); this enabled her to achieve and complete positive learning from an experience of risk management.

5.9 Phil

Phil has been qualified as an ENP for ten years, predominantly in ED. He has previously had managerial and educational roles but is currently purely clinical.

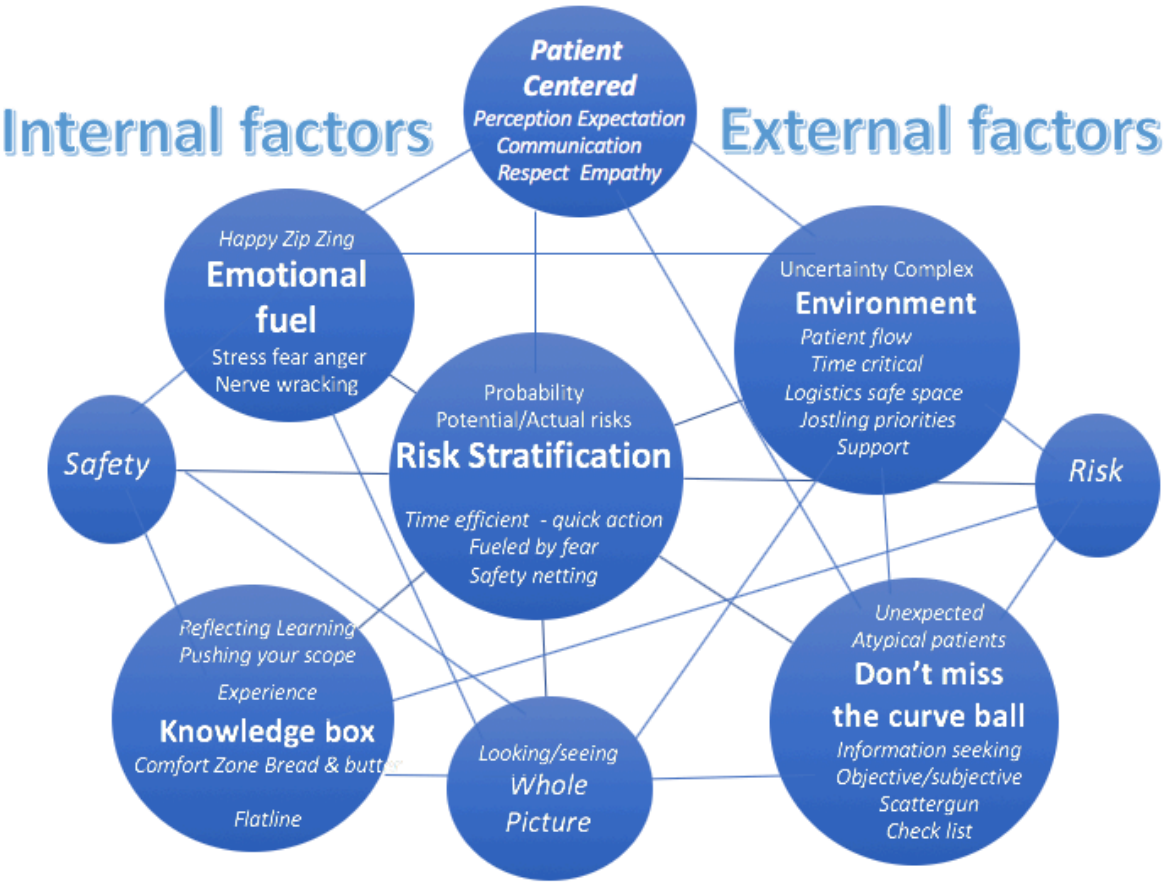


Figure 14: Phil's Lifeworld (see Appendix 24 for thematic table)

5.9.1 Environment – Patient flow - time

Phil experienced his working environment as *constant "patient flow"* of *"a lot of very complex and undifferentiated patients"* (PhiInt2) characterised by

"uncertainty" and limited *"time"*. He was very aware of the *"time-critical"* (PhiInt1*)* nature of his job and their importance of being "*time-efficient"* in his responses to patient risk:

> *[I] got the scan done quickly and also good for the department and good for patient flow, because we had a definitive answer um, and we could move the patient on..the risk was managed* (PhiInt2).

The wider picture and keeping the patient flow was important as it allowed for consideration of other potential unknown risks. The time imperative of urgency to just "*get stuff done"* was evident throughout: *"I've always thought if someone's at risk, I personally get stuff done myself"* (PhiInt1). The time of day affected risk levels, actual and perceptual: "*Risk is worse certain times in the day, towards the end of the day, night…*" (PhiInt1).

Phil referred to the difficulty in finding*:" safe observable space"* (PhiInt1) for patients at risk. *"Overcrowding is causing compromises to the patients"* (PhiInt1). Reflecting that the departments infrastructure was not keeping up with the changing nature or level of risks now presenting: "*I don't even know why they're called minors anymore because they're not minors they're almost major end patients, as I say …they're more complex* (PhiInt1)"; historical terminology does not reflect the reality of complexity practitioners are facing.

Phil referred to "*managing risk through… navigating patient care pathways…to get the right outcome"* (PhiInt2). There was *"constant jostling for clinical priority …"* (PhiInt1*)* due to "*safety initiatives, where it, it makes all of our awareness rise"* (PhiInt2); or following recent incidents:

> *You have a period of a few weeks where people are hyper-aware and hyper-acute… then people slip back to old ways…I think that confuses a lot of the patients …… a lot of the nurses as well"* (PhiInt1).

For these reasons *"consistency is a challenge for lots of practitioners really"* (PhiInt2). There was information overload of *"bits of advice on the walls really (chuckling), so that can be a bit challenging sometimes… I stop reading them at some point…there's too many, they all compete over one another. (PhiInt2)*

Differing perceptions challenges patient referrals: "they'll *want a history, they'll want an examination, they'll want risk factors…"* (PhiInt2). This can be overcome through direct communication of the risk: "*I can talk to someone face to face".* Support from colleagues can reassure: *"[I] let one of the other nurses know that he was there, and I was worried about him, so there was someone else to observe him"* (PhiInt1). Phil referred to the "*confidence"* and trust within a supportive environment: *"I've got a very good safety-net here…I know that in some departments they don't have a very good safety-net"* (PhiInt2). However, he referred to rather than assuming, he often preferred to "*just get it done myself"* (PhilInt1) to avoid a *"mother of all mess ups".*

5.9.2 Patients

Phil's patient-centred perspective ensured patients were informed by:

> *talking about their risk factors, um talking a little bit about their expectations…patients think that a test will make their symptoms get better…try and uncover a little bit more about what's going on behind the symptoms"* (PhiInt2).

Patients may consider their risk higher than the practitioner perceives it to be: *"we're getting increasingly a lot more worried young adults"* (PhiInt1); *or* may

not perceive the risk at all: *"He thought he had some indigestion and I don't think he had it crossing his mind that he'd been having a heart attack. So, as well as administering first aid there was a cross issue of trying to counsel him at the same time…"* (PhiInt1). Describing an approach of empathy and respect:

> *I wanted to treat him properly, I wanted to treat him with respect, give him the best experience of something's that potentially really traumatic. He's just been told he's had a heart attack and what I didn't wanna do is say alright you've had a heart attack and then just pull the curtain, disappear for half an hour and just ask someone to give some medications* (PhiInt1).

Managing risk is also managing the patient:

> *So, my concern was to deal with the clinical need, but also deal with the psychological need. So, I wanted to get, just make sure he was aware of what was going on, what the plan was and to know that he was safe and we were looking after him* (PhiInt1).

5.9.3 Risk Stratification

Phil stated: *"every day there's incidents where we're having to manage risk"* (PhiInt1). Discussing how *"the compromise we're making between safety and managing risk is getting more and more complex"* (PhiInt1). The risk can be *"right in front of me"* (PhiInt1), but Phil speaks of a wider awareness of potential risks than those that are obvious: *"I'm trying to keep an eye on the triage queue"* (PhiInt1). For Phil, there was a sense that if *"you turn your back for a few minutes, and anything could be happening"* (PhiInt1).

All of Phil's reflections involved patients with potentially life-threatening chest pain. He explained, to manage risk: *"you have to rule out the serious things, before you send them on their way"* (PhiInt2).

Phil discussed that when a diagnostic test was negative: "*it did not show a dissection, but again it would have been a very brave person to put that patient on the medical ward and then for them to dissect…"* (PhiInt2), this does not negate the potential risks and reflecting varying levels of risk tolerance. Phil acknowledged managing risk alongside colleagues, *"I realise that they've got their own priorities"* (PhiInt1). Tensions arose when priorities of risk did not align: *"I felt angry* [laughs], *I felt really annoyed that this guy had been put back in the waiting room with that story"* (PhiInt1). *"More junior nurses don't appreciate the acuity of the situation"* (PhiInt1). Nurses may be task-orientated rather than seeing the whole picture and, thus, the risk: *"I think they see it as that jobs, jobs to do…"* (PhiInt1). "*Maybe at that point in my younger career I didn't appreciate the urgency of things"* (PhiInt1).

Initial risk judgements were made quickly *"within a few minutes in discussing risk factors and looking at him and talking about this scenario I was already worried"* (PhiInt1). This *"worry"* can be triggered at any time*: "That was immediately what made me worried when I took the history"* (PhiInt1).

5.9.4 Fuelled by Emotions

Phil responded to situations emotively: *"I'm quite a sensitive soul"* (PhiInt1).

Dealing with risk compounded by urgency, can involve strong feelings such as *"worry" or "embarrassment"* (PhiInt1*).* Subsequent intervention is driven by a need for relief: "*his pain started to subside which was great, I felt a little bit more relieved then"* (PhiInt1). The resolve is a sense of patient *safety*: "*at that point I was quite happy to leave him…he was squared away and safe"* (PhiInt1). Then

"*happy"* replaces "*worry"*: "*So I was quite happy with that outcome… I felt that I'd done something good for the patient"* (PhiInt2).

Negative emotions can be channelled: *"Anger gave me some zing. Made me zip around the department getting things done"* (PhiInt2). For Phil, stress is necessary and helps him to gets things done in a timely manner:

> *you'll find it uncomfortable, it's the yeah, it's a bit exciting, you've gotta embrace it a little bit, haven't you?...And err live on that little bit more, so yeah, yeah it, it's quite challenging and it can always be positive, stress can be a positive thing…Stress gets things done and I spose in relation to these risk management things that we've been looking at, you know, I think on both of them I was stressed* (PhiInt2)

5.9.5 Don't Miss the Curve Ball – Information seeking

When something does not make sense or is not understood or *missing* there is a need for more information: *"…another ECG"* (PhiInt1):

> *…if I've been thrown a bit of a curve ball by a patient, I'd go 'oh what happened there', you know..what did I miss, what…what information did I not pick up.…What, was in their history, or what was in their objective data that I didn't pick up….Patients don't present typically all of the time….patients aren't text books, they come in sometimes with quite different symptoms or, or different histories to how you expect, or they have blood tests you don't expect, or findings on their ECG you don't expect…*(PhiInt2)

Classical presentations often result in a focussed response:

> *When they present classically, it allows you to form a differential diagnosis quite quickly…you manage the risk probably in a more focused fashion. When they present with very diffuse symptoms and diffuse symptomology (chuckling) your risk management becomes a lot more unfocused and I find that the tests I order becomes a little bit more unfocused and you end up just doing quite a lot of tests, looking for something almost like a scattergun approach.* (PhiInt2)

On describing the *scattergun* response to uncertain presentations:

> *I'll fire this and just see what comes back…It almost becomes a bit more veterinary.…Because you're just trying to see what, what there is, and that, that's dangerous… Well it's dangerous because you end up finding things that maybe didn't need to be found, so (chuckling), err there's a lot of patients I'm sure walking around with a lot of pathology that don't even know it's there and probably may have died with that pathology and wouldn't have known differently…. But then as we know hospital treatment, hospital investigation has risks, has side effects. So sometimes just finding something can increase their risk. Well I don't know, even just, even just hospitalising someone is dangerous isn't it, we know there's risks with being hospitalised.* (PhiInt2)

Thus, Phil identified the risks of interventions intended to enhance safety.

5.9.6 Comfort Zone of Knowledge Box – Nerve rackingly pushing your scope

Phil referred to a *"comfort zone"* of knowledge in which he is very familiar and "*comfortable": "with a presentation that is so classical and so bread and butter to my job"* (PhilInt2) "*…It puts me back in my comfort zone… I don't have to think about what to do with the patient, it's almost automatic"* (PhilInt2). Although knowledge gives you confidence he warned: "*you can become quite um, you know set in your ways, stuck in a rut so to speak…And you, unless you push yourself, you're not gonna learn anything new"* (PhiInt2), as described in the following*:*

> *I think nerve-racking is, I think it's an area of growth, I think when you're slightly stressed and a little bit nervous, it means that you're probably pushing your scope of practice enough. Um, I try not to be frightened, a little bit nervous is good and a little bit stressed is good um and it's an exciting area of pushing your practice. I think if you don't feel like that, you're not pushing your practice enough.* (PhiInt2)

Phil reflected on a patient who *"for some reason he was there in my mind"* (PhiInt1) indicating an unresolved feeling of either something not known or understood therefore potentially a learning opportunity*: "When I reflect, I change my practice,*

but that change sometimes wanes, not wanes, but I think then, other things creep into your practice…might have been diluted somewhat into another area of focus." (PhiInt2)

> *I've experienced sadly people who have had cardiac arrests in my waiting room…you don't always learn through positive things, you learn from sometimes bad things happening…I've had my fingers burnt on a few occasions…maybe not from personal experience, but from other colleagues…when something bad happens, erm, that's turned into a learning point…*(PhiInt1)

Bad experiences can lead to avoidance "*it'll make you less likely to embrace the more complex patient. So, you will get, you will stick your, you will, you will maintain a status, not a status quo but a, a comfort zone in the types of patients that you see (PhiInt2).* Phil attributes his level of experience to his confidence:

> *If you don't see anything beyond your scope ever, then you're never going to be confident to see anything beyond your scope….And then I think that's just an ever a downward spiral, and you end up just being under confident…And I think if you push yourself a little bit harder…it's quite surprising what people can see and can do…I think confidence is the issue.* (PhiInt2)

Knowledge growth is an emotive experience and "*to stop learning is to Flatline"* (PhiInt2).

5.10 Steve

Steve has twenty years' experience as an ENP, initially in ED, but has been in his current setting of a MIU for the last fifteen years. He is predominantly a manager, but a proportion of his role is clinical.

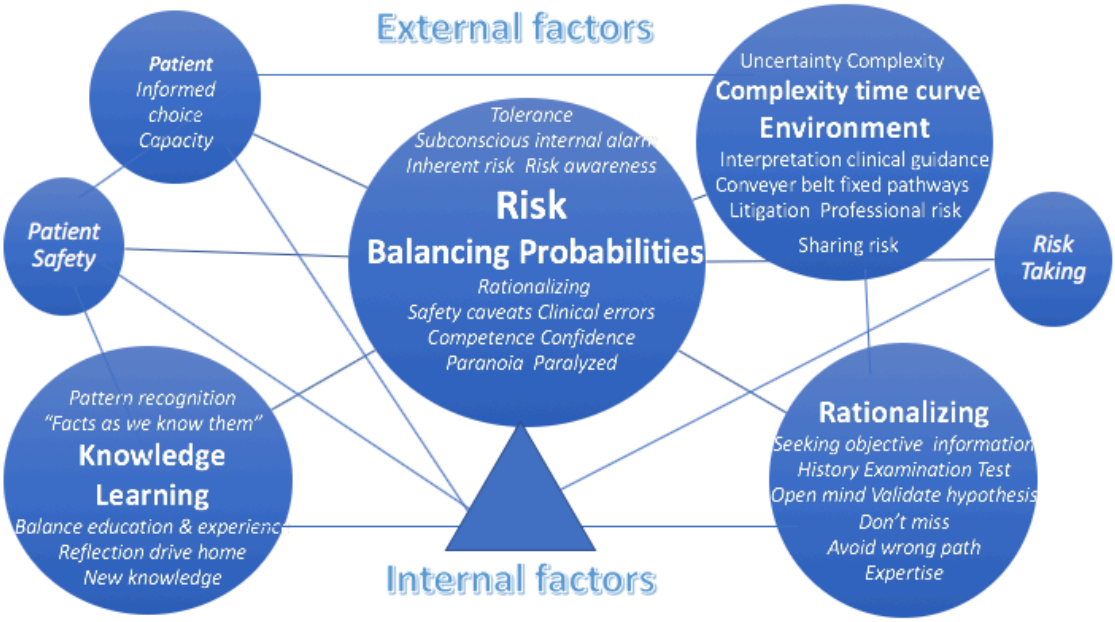


Figure 15: Steve's Lifeworld (see Appendix 25 for thematic table)

5.10.1 Balancing Probabilities of Risk

Steve stated that the lifeworld of an ANP is *"inherently fraught with risk*" (SteInt1) and decisions around risk need to be based on a "*balance of probabilities*" (SteInt1/2). Referring to risk tolerance, he stated that as clinicians:

> *We need to manage risk, but we need to manage risk comfortably, safely and, and actually bearing in mind, our own sort of resilience to that… it's an interesting job, it's an exciting job err it's a challenging job um and but it, at the same time, managing that continuous level of uncertainty…"* (SteInt1).

Reflecting on his own high tolerance of risk, Steve questioned: "*does that make me a cavalier um person or, or am I, or are my actions sort of measured and reasonable and responsible?*" (SteInt1). He described having a "*subconscious internal alarm system*" (SteInt2) alerting him to potential risk. As a manager he reviewed clinical errors, "*that level of insight makes me more cautious perhaps of the pitfalls*" (SteInt2). Steve refers to the inevitability of mistakes having witnessed "*good clinicians"* who:

> *Have a hiccup, um, and you know, maybe lose their confidence after an event which, which will happen because you know, it has been said that "if you…if there aren't the occasional clinical errors made or diagnostic errors, you're probably not seeing enough patients.*" (SteInt1)

Steve referred to "*managing risk"* through "*probability"*: *"…because if we go down the route that every bellyache in every man over 55 erm… might be an aneurism…we can't scan all of those people. We've got to have at threshold of probability…you need to manage that risk"* (SteInt2). Steve warned against being "*paralysed by fear*" (SteInt1) or "*clinical paranoia*": *"it's something that needs to be kept in check, because there's, there's a degree of caution, concern, stroke paranoia, or clinical paranoia if you like, you know, with a reason and a rationale, um and, and that's good."* (SteInt1). Furthermore:

> *If an individual sort of carries around the gravitas of responsibility so much so at the front of their mind that they're going to be paralysed potentially into not making any decisions, not making any judgements because they're worried excessively. So, it's getting that balance of awareness, having it just below the conscious level.* (SteInt2).

Steve highlighted the importance of understanding "*differing levels of risk*" (SteRef1). Less experienced ANPs may be ignorant to the risks: "*what they don't know doesn't scare them*." (SteInt2). Indeed, *"competence level doesn't match their confidence level. Conversely, there's a number of clinicians that are really, really competent but lack confidence."* (SteInt2). Steve described his "*irritation"* at the "*reticence"* of a more junior ENP to carry out a certain procedure (SteRef1), differing perspectives on risk causes conflict.

Steve referred to the importance of *"interpretation of clinical guidance rather than an automatic process of putting a person on a conveyor belt, such as a specific chest pain pathway"* (SteInt1).

> *Do people in Emergency Departments overly rely on fixed pathways you know, renal colic goes down that route, headaches go down that route, chest pains go down that route….fixed protocols really don't fit the majority of patients, very few patients will fit a very specific algorithm whether it's an isolated extremity, injury or, or somebody with a cough…one of the first things that the Service Manager and myself did when we were appointed was sort of tear up those fixed protocols and replace them with clinical guidelines. Um, because fixed protocols really don't fit the majority of patients, very few patients will fit a very specific algorithm*
> (SteInt1).

5.10.2 Environment

For Steve, decisions about risk were contextual and made according to time and place: "*under normal circumstances I would not consider this option*" (SteRef2). Steve's management of risk and patient safety happened in an environment increasing pressured by organization, society, patients, and ANPs themselves: "*higher expectations comes with a higher level of risk management*" (SteInt2). Steve warned that risk taking in on an upwards trajectory: "*What may have been*

considered complicit in a 'Never Event' a few years ago are now not uncommon" (SteRef1).

Referring to professional risk of managing risk: "*I exposed myself and my organisation to potential criticism. It could be argued, weakly in my opinion, that I was breaching an NMC code of conduct*" (SteRef2).

Steve discussed an environment in which, due to "*resource issues",* such as long ambulance waits leads to "*suboptimal care"* causing practitioner "*frustration"* patient "*anxiety"* at times leading to increased risk tolerance, such as "*transferring potentially unstable patients in cars rather than ambulances*" (SteRef2).

In the context of uncertainty, there was an element of luck or superstition in managing risk: *"I am very comfortable… looking around for some wood to touch… that, that, that judgement was correct at that time"* (SteInt1). The element of "*at the time"* is crucial. Steve referred to a "*complexity time curve"* noting that some patients with *"comorbidities, complexities, um either medical, psychological, or social, end up being with you for a longer period, um that usually affords you the time or to, to sort of gather additional information"* (SteInt1).

Sharing the risk by *"discussing management"* (SteRef1) with seniors or patients: *"we discussed with the patient and her husband treatment options"* (SteRef1). Steve explained: "*my actions were in the patient's best interest given the circumstances*" (SteRef2). He discussed the patient being "*grateful"* when a "*potentially riskier strategy paid off….the patient avoided hospital and went home*" (SteRef1).

5.10.3 Rationalizing – Through available and relevant information

Rationalizing for Steve was seeking evidence in order to understand and objectify a feeling for judgment based on expertise or experience. Steve summarizes:

> *What we do…is rationalise, work out based on education experience, um and, sort of pattern recognition…the severity of an initial presenting complaint…gather the relevant information available…combine that with a diagnostic, or a clinical examination, history taking… err clinical measurements parameters to sort of put that into the mix, um and then hopefully come out with a working diagnosis…searching data that will, err reaffirm and validate the initial hypothesis, bearing in mind…common mistakes are that you err fix on a diagnosis too early in the process, and that can lead you potentially down a bit of a wrong path."* (SteInt1)

In explicating the history taking, he said: "*So it's not necessarily a case of sort of prodding and probing and poking the patient as much as actually listening to what they're telling you, keeping an open mind*" (SteInt2). This "*open mind*" involved "*having a broad idea what the most likely probable cause of that person's presentation is, seeking sort of validation from examination and history"* (SteInt1). The benefits of history taking, he stated: *"Don't delegate someone else to obtain the patient story because that's when things get missed"* (SteInt2). Steve explained:

> *A clinician, after a period of time, has seen most broad categories, every patient will fit in a sort of pigeon hole, um and within that pigeon hole, you, you know you then need to sort of delve in further to err to sort of explore those theories, those hypotheses further, um, and then sort of, once you've reached um a probable diagnosis or certainly an initial clinical impression, err is then base the treatment plan* (SteInt1)

Thus, Steve was warning that for early diagnosis further information was needed so not to "*miss"* something it is important to ask:

> *Is there an acute event that I don't want to miss there and I need to explore that, and satisfy myself, um that you know, my, my err initial impression err is probably right and that subsequently my initial management plan um and discharge plan is safe and correct.* (SteInt1)

5.10.4 Knowledge/Learning

Steve's knowledge was based on:

> *…pattern recognition, which supports the education over the years erm, but what we need to do as a professional group is get the balance right of education and experiential because one without the other is relatively erm meaningless and might be potentially dangerous. Erm, and you know the two need to go hand in hand*. (SteInt1).

When faced with something new or unexpected there can be "*tinge of anxiety*", "*apprehension*", particularly when taking a potential risk and the expected outcome of treatment did not happen (SteRef1). Steve sought to understand using his knowledge to "*rationalise"* (SteInt1/Ref1) which he described as: *"work out um based on education experience, um and to a greater or lesser extent, sort of pattern recognition, um, you know, the severity of an initial presenting complaint*" (SteInt1). He described how this information was "*put… into, into the diagnostic mix. Um, a lot of that we tend to do without consciously being aware of it*" (SteInt2). Questioning the term intuition: "*we sort of tend to err think that we're being intuitive as opposed to really basing it on err sort of our learnt behaviour, err our taught experiences, um and, and the facts as we know them"* (SteInt1). Thus, he commented on the facts "*as we know them*", emphasizing the perspective of knowledge in terms of not what we know but the way in which we know.

Following an incident whereby risk had been managed with a high degree of uncertainty can cause feelings of worry and concern after the event: *"this was not*

someone that gave me a sleepless night" (SteInt1). Steve describes a subconscious reflection driving home*:*

> *…third set of traffic lights on the way home, or in my case, it was always the first set of traffic lights and a roundabout, I'd sort of turn round, go back to the hospital and just check something that I'd done probably just two hours before to make sure that I could sleep comfortably that night* (SteInt1)

This may be the subconscious alarm system through a mental check list of making sure everything has been done.

"Supporting" others to take risk safely can be an "*invaluable learning experience"* (SteRef1). Steve described how he was able to use an experience of supporting a junior in managing risk and "*turn it into an educational event (with patient consent!)*" (SteRef1). Recognizing the educational value of mistakes:

> *Erm, so one of the key things is supporting our staff when things don't go necessarily right, erm and trying to learn from those errors and share the learning points, not just within our own immediate workforce but with emergency nurses erm at a much wider level.* (SteInt2)

Steve eluded to needing risk to maintain enthusiasm as this motivates him to advance his practice: "*a relentless flow of fingers, cut heads, and ankle injuries, probably gets quite boring. Um, and, and very unchallenging*." (SteInt1). With experience comes an ability to have a greater "*appreciation of risk management"* and "*a greater job satisfaction"* (SteInt1).

5.11 Ted

Ted has eight years' experience since his ENP qualification; the first seven years in an ED and a recent move to a new setting where he now works in a semi-rural MIU

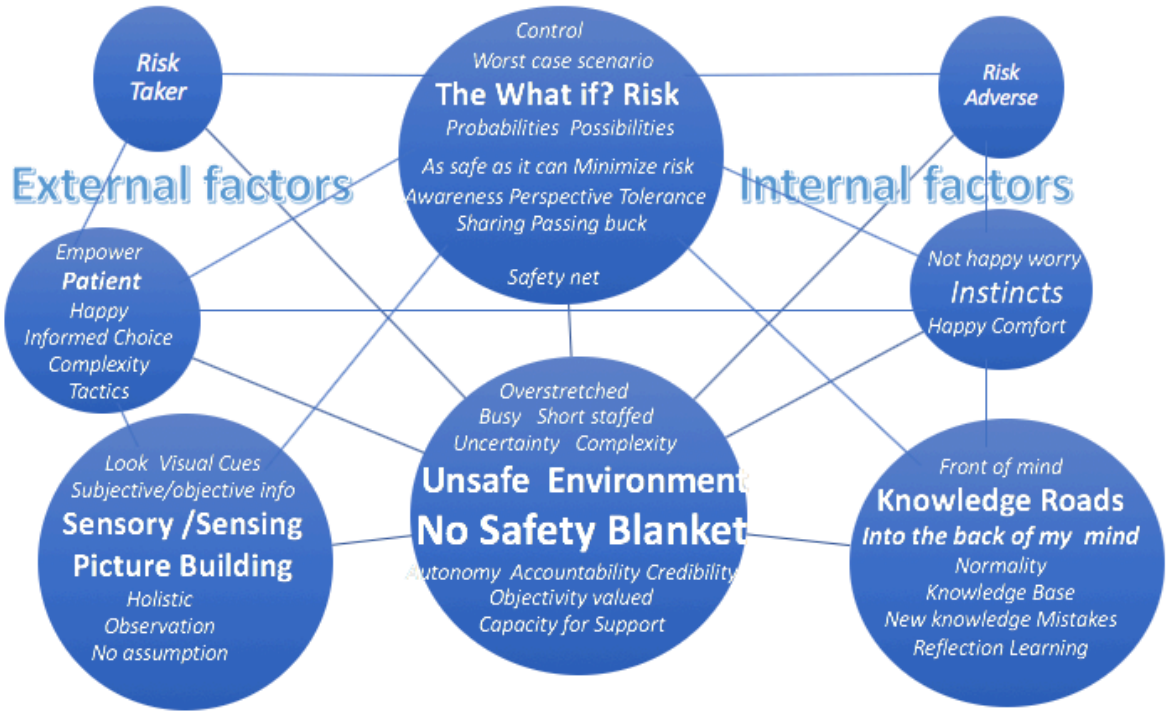


Figure 16: Ted's Lifeworld (see Appendix 26 for thematic table)

5.11.1 Environment – No safety blanket

Ted referred to his workplace: *"from a risk point of view, (it) can be a very unsafe environment to be in*" (TedInt1). He indicated this risk was due to business, distance from nearest hospital, overstretched GPs, short-staffing, autonomy, isolation and uncertainty. Risk was time critical requiring quick action. Having time to spend with patients could "*ease"* the burden of risk but "*when it's busy, you kind of have to compromise…*" (TedInt1).

Referring to his previous work environment ED in which there was the "*luxury"* of support and patients were "*packaged"* by triage, where the risks were "*filtered"* out and you were "*seeing the safe stuff*" that had been "*put into slots*"; it's a "*very protected environment*" (TedInt1). In contrast, he referred to the

autonomy of working in a nurse-led unit *"Its, your decision at the end of the day, as opposed to having that safety blanket* (TedInt1).

In the "*medical profession, we tend to rely a lot on the objective facts, but quite a lot of what we do is um, has a subjective base to it as well"* (TedInt1).

> *If you try and refer somebody based on how they look…it doesn't give you the same clout does it, if somebody's got barn door, ST elevation on their ECG* (TedInt1).

For Ted, being credible in a medical environment that does not recognize subjectivity can be a challenge in order for ANPs to be considered *"credible as practitioners to… rely on sort of objective facts, rather than just going on you know, a bit of gut-instinct"* (TedInt1). In the absence of objective facts, he used "*other little snippets of information*" and has "*little tricks that aid your referral*" such as using the term *"they don't look right"* or *"the parents aren't happy"* (TedInt1).

5.11.2 The 'What if' Risk

For Ted, managing risk was being aware of its' potential and "*trying to make sure that your practice is as safe as it can be"* (TedInt1). There was an assumption of an inevitability of risk in practice and coping with it though "*trying to minimize risk*" (TedInt1). "*My decision was influenced by potentially what could happen and ensuring the patient received the best possible care and by the most appropriate… provided, in the safest way*" (TedRef2). Ted discussed risks in terms of "*worst case scenario…cardiac arrest and die"* (TedInt1).

He described a need for a "*constant awareness"* (TedInt1) of risk during busy periods describing the risks layering or building:

> *If you're short staffed, um, then it only takes you know, somebody with chest pain to come in, or you know, somebody else that's unwell to come in, and that is your, that's your staff tied up with that… So, anything else that books in on top of that, um, you know, it would be a very difficult situation to manage, and that potentially could be quite unsafe…So, I think that isn't, in the back of your mind, you know, especially during, um, busy periods.* (TedInt1)

Potential for risk leads to worries about the safety of his "*registration at risk" (TedRef2). "It's always in the back of your mind that if something does happen, then you know, you are the last practitioner to have seen him and your decisions will obviously be scrutinized if anything does happen"* (TedInt1). Ted spoke of the need for "*self-preservation"* (TedInt1) and heightened awareness when faced with complexity such as *"elderly collapses, head injuries and chest pains, just because of the uncertain nature of them"* (TedInt1). He stated the importance that "*your notes will back up your decision… protect you really"* (TedInt1).

Risk tolerance was on a scale of being "*flippant…you've got chest pain; I'm going to send you home anyway"* (TedInt1); or "*err(ing) on the cautious side*" (TedInt1). Referring patients on alleviates feelings of concern: "*to me, he was safe. Because he was in an ambulance, so it kind of takes the onus off, off you a little bit*" (TedInt1). Coping with risk could be through "*safety-netting"* discussing "*red flags…or any deterioration or anything they're worried about, then make sure that you've given them the information to know what to do*" (TedInt1). Thus, handing the responsibility to the patient.

Differing perspectives of risk tolerance arose. Ted judged others as being *"over the top"* (TedRef2) in hospitalizing a patient based on something that "*might happen"* (TedRef2). Risk was ranked according to potential consequence: "*they're*

not gonna die from their, from their injured foot…" (TedInt1) but can "*quite easily die from their chest pain*" (TedInt1). Nevertheless, patient satisfaction was a factor: *"The patient was happy by the treatment choice*" (TedRef2). Ted referred to the challenge when his professional opinion conflicts with patient expectations: "*I could see that the patient thought an X-ray would have provided the 'best' treatment and by not providing this they felt disappointed*" (TedRef1). There was pressure to do the "easy-thing":

> *I could have just X-rayed the patient to avoid the unpleasantness/complaint, but clinically this wasn't indicated and there is inherent risk to X-raying, which was explained to the patient at the time* (TedRef1).

Additional challenges with patients who were "*keen to take the risk… if he'd have gone home, to me, he would have been at considerable risk* "(TedInt1). Whilst recognizing the patient "*is an adult, he had every right*" to decide his fate, Ted referred to the *"frustrating"* or "*awkward position"* when the patient is going against advice: "*He had capacity to do it. Um, but obviously I didn't think that that would be the right um decision…"* (TedInt1). Ted described giving patient "*clear"* information to "*empower"* the patient to make an "*informed decision about what would be the best treatment"* (TedInt1). Ted described using *"harsh reality"* and "*shock tactics"* and using the patient's wife to help persuade the patient not to take the risk (TedInt1).

5.11.3 Sensing Picture Building

In Ted's *lifeworld*, achieving a complete certain "*picture"* of objective information leads to a sense of "*happiness"*, "*reassurance" (*TedInt1) *and* enablement to manage risk well. "*Confident actions*" (TedRef2), based on research and objective information protects against "*being bullied into making wrong decisions*" (TedRef1). A trigger for a need for more information can come from a sense of something *not being right:*

> *There was just nothing sort of objective about him, that I could sort of put a finger on and say…he just had that look of not looking right…Um ECG wasn't particularly conclusive, um but I just wasn't happy with his presentation…. Its important all the information that you need or that you can get…To enable you to make an informed decision, um, that it's the best decision for you and the patient"* (TedInt1).

The "*right"* information is achieved though targeted assessment "*my examination, my history was um good, just because it enabled me to get the information that I needed from them*" (TedRef2). Information available is often limited by circumstances such as, willingness to share or receive information for colleagues and patients and access to information according to setting "*we don't have all the diagnostics that you would have in a hospital*" (TedInt1).

For Ted, feelings guided his practice: Being "*worried", "scared"* or "*anxious"* identifies potential risk; Being "*cross", "angry", "frustrated"* or *"helpless"* when unable to control or manage the risk in a way he feels is right is perhaps hindered by factors such as environment, patient wishes, colleagues or time. *"I think there are certain things that worry me, sort of autonomously working in this sort of job"* (TedInt1). *"I wasn't happy to say that this was muscular chest pain or this was*

indigestion, without, you know, to rule out anything more sinister, was obviously on the back of my mind really" (TedInt1). In order to be happy "*to safely discharge a patient home, I would need to satisfy certain criteria"* (TedInt1).

If "*not happy"* (TedInt1/Tedref2) then this leads to a "*worry of a something not being right": "there was just nothing sort of objective about him, that I could sort of put a finger on and say "Well you know, you, you don't look well", he just had that look of not looking right"* (TedInt1). Referring to a patient he was "*not happy"* about, he stated: "*objectively, he was well, but subjectively he wasn't… So, the tests that I was doing on him were all, were fine, but he wasn't… he had 'that look'"* (TedInt1). Ted describe "*that look"* as being based on:

> *Your instincts as such and your ability to, with a bit more experience, to be able to recognise when somebody just doesn't look well, or something isn't right with them, even though you haven't got the, the sort of data, or the hard facts to be able to sort of back that up….He just didn't look particularly well, um, he looked a bit pale, um, I could tell that he probably wasn't giving me all the information that I was after, because he didn't want to be admitted, so I think he was probably holding back on some of the symptoms that he had… so I don't think he was telling me the full picture*. (TedInt1)

Thus, sensing risk through a subjective feeling of an incomplete picture. Despite valuing instinct, Ted stated, you need to "*rely on sort of objective facts, rather than just going on you know, a bit of gut-instinct".* However, in order to fill the gaps of the missing pieces, Ted referred to "*building a picture"* of a situation in which both objective and subjective perspectives come together:

> *It's trying to sort of put those two things together really…which often will give you quite a sort of clear picture about what's going on, but I think the balance will slightly tip towards the sort of subjective, which made it a bit more difficult. to sort of formulate the picture if you like. It's sort of using different*

little bits of information to sort of come to a diagnosis…build-up that picture" (TedInt1).

Upon creating this picture, you then "*look at the bigger picture and something doesn't seem right…something might be missing….*" and the worry of uncertain risk can remain. A successful measure of risk management for Ted was to be able to *"go home and be able to sleep at night really which… working in this environment, can be sort of difficult to do sometimes"* (TedInt1).

5.11.4 Knowledge Roads – Into the back of my mind

Risk and patient safety is managed based on current knowledge: "*it's important that practice is guided by up-to-date, research-based information*" (TedInt1). Ted referred to knowledge that sat at the *"back of my mind"* (TedInt1) enabling him to "*know"* things or make quick judgments: *"If somebody comes in, in their twenties with chest pain then it's a very different presentation to someone that comes in, in their sort of fifties"* (TedInt1). This initial judgement sent you down a "*coronary heart disease road".* However, the process of exclusion must happen on the way. With experience "*you quite often will go on how people look and how people seem*" (TedInt1) and rely on "*instincts to recognise when somebody just doesn't look well*" (TedInt1).

Reflecting on the way home can bring *worries* to the front of the mind:

> *Quite often at the end of the shift, you will drive home thinking oh my God… I quite like to be able to drive home at the end of the day and be able to think, well actually, there's nothing gonna happen that's gonna make me come into work tomorrow and have to account for why this patient's ended up in a sort of compromised position*. (TedInt1)

For Ted, this reflection was a time to consider if he had "*done everything you can*" (TedInt1) and the patient was "receiving the best possible care in the safest way" (TedRef2). Thus seeking a feeling of relief or reassurance that patient's safety is not compromised, asking such questions*: "have I made the right decision about that? could I have done anything differently*?" (TedInt1). Risk experiences were learning potentials: "*you sort of build on your experiences that you've had in the past, good or bad to help you practice, we'd sort of reflect on mistakes and hopefully develop from those to inform our practice….in the future*" (TedInt1).

5.12 William

William has been an ENP for five years and has trained, and still works, in ED.

Figure 17: William's Lifeworlds (see Appendix 27 for thematic table)

5.12.1 Environmental Boundaries

For William, the context of ED defined its own clear boundaries for ENPs, if "*it's not acute, go away*" (WilInt1). William referred to the difference between nursing approach and reliance on subjective assessment such as "*I don't like the look of this patient*" (WilInt2) and the difficulties in communicating this to others/doctors who require objective information such as test results. He speculated that historically this may be due to the longer time ENPs spend with their patients. However, ENPs no longer have the "*luxury"* of time, yet still value this feeling-based assessment. Limited "*time", "resources"* and boundary issues between professionals and differing "*priorities"* are important issues. He described negotiating with colleagues to secure a timely CT scan.

He described his ED environment as more risk-adverse than most "*due to previous bad episodes*" (WilInt2). It is from these bad episodes that things are "*plucked out of the air*" (WilInt2) to heighten an awareness of risk and become the current "*golden goose"* not to miss. He referred to the restrictions on ENPs feeling like "*we've been clipped back*" in terms of their scope: "*we'll let you see this, we'll let you see this…*" (WilInt1). William described himself as "*subservient*" (WilInt1) to more experienced colleagues with whom he shares risk, seeks support and second opinions. However, this hierarchy of opinion can lead to "*pressure*" or "*encouragement to investigate a little more that I would have previously*" when actually on the incident he had been reflecting on, he had been "*quite comfortable that the patient didn't have…*" the potential red flag or "*golden goose*" diagnosis (WilInt1/2). William referred to further pressures from guidelines which he stated

were "*not rules or absolutes*" but should "*guide", "help",* rather than "*push"* or *"lead"* and justification is important if "*sphering away"* (WilInt2).

He acknowledged the increase of the "*complexity*" of patients for whom there is often no clear diagnosis, whereby they do not "*fit in a box*" (WilInt1). He also described having to work with the uncertainty through "*the balance of probability*" (WilInt1/2). The fear for William was the unknown, not knowing, and perhaps being over emotional and not making rationally-based decisions.

5.12.2 Don't Miss the Golden Goose - Risk

William formed an initial picture of the patient situation and from this there may be an alert "*trigger"* for risk (WilInt1). An awareness of risk came from uncertainty, as to whether the patient was *"sick or not sick"*" (WilInt1) or knowing that "*something is missing"* (WilInt1/2). He described his experience-based "*intuition"* (WilInt1) as helping him to give a global picture that enables coping with uncertainty towards a potential understanding (WilInt2). There was an awareness of a need *to "not miss the 'golden goose"* (WilInt1).

Risk-coping behaviour can involve "*passing the buck*" (WilInt1/2) either to the patient or referring to another professional. For William, the alternative to this was "*the buck stops with me*" (WilInt1). This was a decision made based on William's perception of his sphere of competence, confidence, and comfort.

Risk taking is "*uncomfortable"* but this feeling of discomfort dissipates if information comes to light that proves he was right: "*justified that CT was normal*" (WilRef1) and there is then a resolution for this feeling; this leads to an awareness

of *"pushing the boundary"* of your practice (WilRef2) and then the "*barometer is reset*" (WilInt1) to be able to deal with more risk in future situations

William referred to giving patients choices: "*Do you want to get imaged*?" (WilInt2). Providing patients with information, pros and cons, "*probability"* (WilInt1/2*)* and likelihood, rather than being paternalistic and owning the risk himself. This strategy particularly aids in "*complex decisions",* particularly with illness patients as opposed to injury patients where decisions can be "*more clear cut"* (WilInt1) and guidelines can be followed.

5.12.3 Form a Picture – Seeking information

William described that there is a feeling that there is "*something a little bit more to the consultation than met the eye…*' (WillInt1/2). This is followed by behaviour patterns of information seeking, such as "*doing X-rays, bloods and that kind of stuff...*" which he describes as a "*rigmarole*" (WillInt1). Reflecting on an incident where he may have missed something, he questions why "*he didn't see the cue… or didn't push... that questioning a little bit more…*" (WilInt1). In not fully exploring the potential differentials in depth, and in the case of the first reflection of "*only looking for things that confirmed…my initial thought…*" (WilInt2), William felt he exposed the patient to potential risk through "*confirmation bias*" thus not being open to other possibilities leading to something being missed.

> *So, you're looking… you're knowing a little bit about it and not, you know diving in … in … in depth about, you know, the specifics of confirmation bias. It was kind of, you know, look … I was just looking for things that confirmed my … my initial thoughts of…probably had I not read that…probably I would have been more open to thinking about other things* (WillInt1).

Indeed, William referred to how, in hindsight, *"the symptoms fitted the TB picture"* (WilInt1). The "*culprit"* being a book he read about a misdiagnosed cancer that led him down the wrong path in which he did not value or "*see"* or "*seek"* the right information.

5.12.4 Inner Voice – Subjective feeling

William valued his intuition in managing risk: *"I trust my gut more so than science sometimes"* (WillInt1). Describing intuition as

> *that kind of sixth sense…nursing sense or…spidy sense…intuitive…there's something that's going on there, but I don't know what…and I think we're more likely to tease that out. there's something not right in that picture*…maybe missed something subtle, because then intuition says something….*probably not every nurse has it…medics that have it as well….Probably the more senior medics...*They learn to trust their gut… (WilInt2)

William discussed how "*something, somewhere was saying they (the patient) needed…to be seen sooner"* (WillInt1). It was not only a trigger but a driving force. He talks about a "*really strong kind of power*" that he relates to nurses, *"somethings not right", "something else is going on", "you need to do something else",* "*we can't explain stuff but we just know…and something we are right and sometimes we are wrong*" (WillInt1). He described his intuition as "*questioning*", something that "*doesn't let you sit*" and he "*does not care whose head I jump over… if I think it's the right thing I will act on that feeling…not being able to stop…keep going until…*" resolution and comfort (WilInt2).

There was a strong visual element "*I don't like the look…when you actually look at them*" (WilInt1) giving you a "*global picture*" to establish quickly if a patient

is sick or not or knowing whether you are missing something (WilInt1). William referred to the fact that caution needed in this feeling-based assessment and not "*going mad or going over the top*" but being within the boundaries of reason, acknowledging "*finding where the, where the boundaries are… can be quite challenging*" (WilInt2).

5.12.5 Knowledge Boxes

William described *"knowledge boxes"* when you are faced with familiar or straight forward risk scenarios that neatly fit into boxes and patterns are recognized; this is William's "*comfort zone"*. William identified that there is greater risk when presentations don't fit in a box or the knowledge is not there: *"There's more likely… the risk… the acceptance of risk when there's a… not a great probability either way or when our knowledge base isn't great"* (WillInt1). There is an acceptance that "*you can't know everything*" (WilInt2). There was a sense from William that your experience or knowledge allows you to really *"see"* something:

> *I didn't see that actually she had night sweats and, you know, although she had a TB jab that actually there's still a real possibility as you get older… that you can, um, you could get TB* (WillInt1).

With more knowledge or experience, William may have "*seen"* this potential. With this *"seeing",* the situation is understood and, therefore, so is the risk.

William described the experience of discharging a patient with an uncertain diagnosis as being outside of his *"comfort zone".* Although other colleagues were

reassuring him it was safe, he felt that the patient was *"going into the unknown".* This, for him is "*pushing on that boundary a little bit*" (WilInt2).

> *It's easier to say, to see you know on a night shift twenty people well within your comfort zone without perhaps, you know pushing that boundary where you need to take a little bit more time and think a bit more…"* (WilInt2)

William discussed competing with the pressures of the environment where you have to see patients as quickly as possible.

> *… but then the argument is that actually if you push your boundaries next time you can see your comfort zone gets bigger…so therefore you can see a greater amount of people more quickly…so then the long-term vision actually is the more you see the more exposure you've got, the more patterns you've got…the more you see…* (WilInt2)

He also inferred that to progress you need to go out of your comfort zone, and that comfort zone is where, *"the edges of, yeah it's exactly where risk is, but realising there's risk within the comfort zone as well …*" (WilInt2).

5.12.6 Beneath the Wings

William felt that he had progressed quickly in his career and was therefore "*exposed to risk"* earlier than others. He attributes this to having supportive mentors with whom he was able to take risk under the safety net of these more experienced practitioners. With this early exposure, he also stated he was less afraid of risk than others because he felt he was able to balance the probability in order to work out the right decision. William believed this support from others has been the key to his learning and development. He described himself as being really lucky to always have had someone to take him "*under their wing right through to*

where I am today" (WilInt1). Many of William's analogies referred to birds: "*beneath the wings", "clipped back", "plucked out", "golden goose".* The conceptual framework illustrated a wingspan between risk adverse and risk-taking. As the least experienced ANP in this study, an interpretation of his lived experience of managing risk was also interpreted spatially (sphere, zone, boundaries), perhaps describing a sense of learning to fly.

5.13 Collective Worldhood of the lived experience of managing risk and patient safety – A Heideggerian Interpretation

This section provides an interpretative description of the collective *worldhood* that emerged from all the data through a Heideggerian lens.

In referring to *worldhood* Heidegger (1962 p.64) himself asks:

> Does every Dasein 'proximally' have its world? Does not 'world' thus become something 'subjective'? How, then, can there be a 'common' world 'in' which, nevertheless, we are? And if we raise the question of the 'world', what world do we have in view? Neither the common world nor the subjective world, but the worldhood of the world as such.

Thus, Heidegger (1962) is questioning the authenticity of any interpretive description of a collective *worldhood.* Dreyfus and Spinosa, (1997) point out that "As mortal disclosers of worlds in the plural, the only comprehensiveness we can hope to achieve is our openness to dwelling in many worlds and the capacity to move among them". It is my contention that having explored the subjective *lifeworld's* of each participant it is necessary to interpret these findings collectively to acknowledge the world within which each of these *lifeworld's* are experienced in order to make it

meaningful outside of individual subjectivity. Thus, the collective worldhood themes are:

- Conveyer belt environment (*thrown into world, lifeworld, worldhood*);
- Patient sharing (*care, being-with, others, discourse*);
- Coping with risk (average-everyday *coping*);
- Mood – fueled by fear (*care, concern-towards*);
- Seeking Information (*Revealing, concealing*);
- Knowledge comfort zone (*forehaving, understanding to interpretation*).

See Appendices 28 and 29 for final collective theme tables. Figure 18, below, shows these collective themes and how these are interconnected.

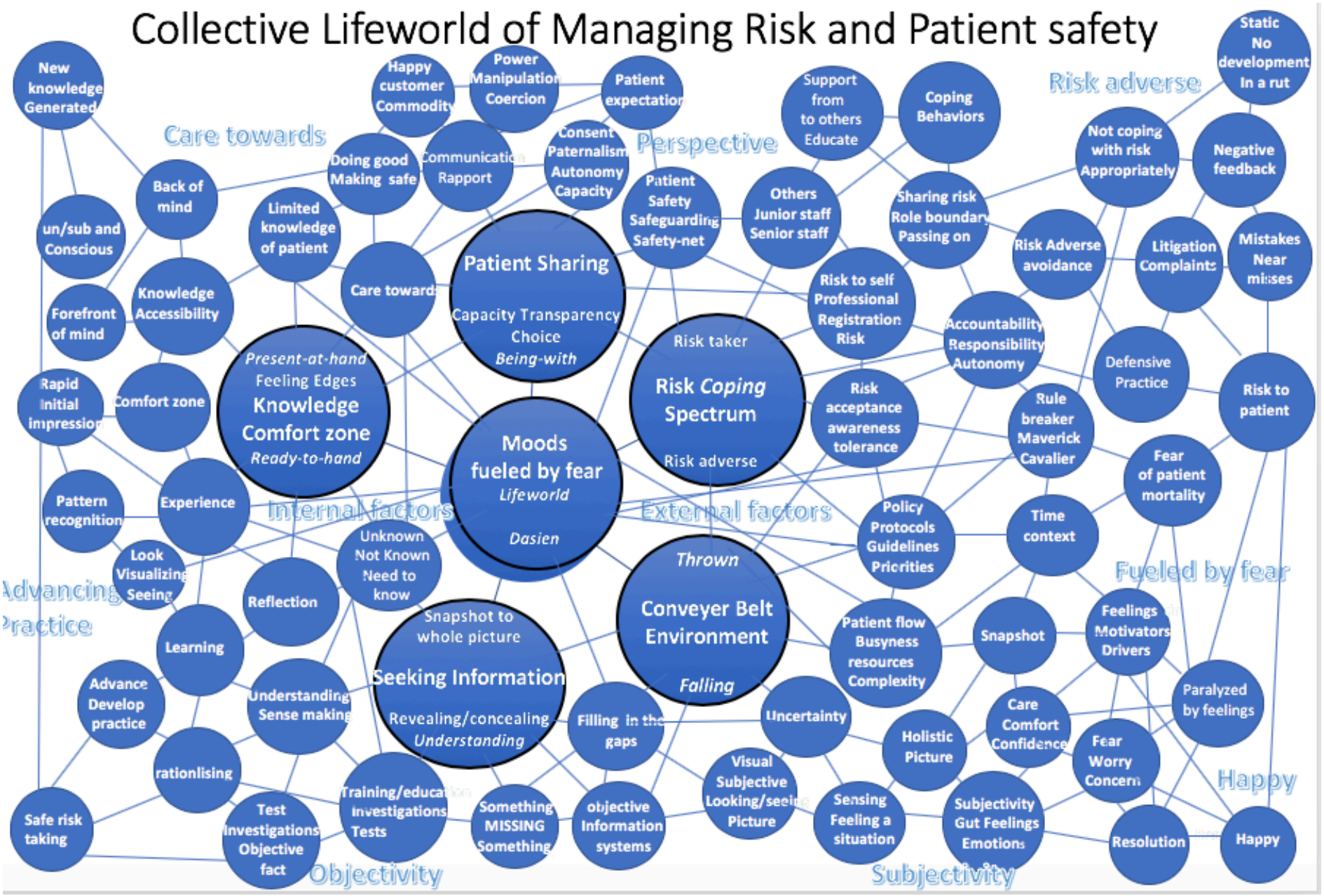


Figure 18: Collective Worldhood

ANPs are *thrown* in to an environment driven by time pressures within which they are coping (*falling*) when balancing probabilities of patient risk and safety with their ability to cope at moments in time. Coping is dependent on the presenting situation, breadth of knowledge-base, application of knowledge, degree of perceived support, and channelling of emotive moods. In situations of uncertainty, insufficient knowledge and/or lack of information, the practitioners were guided by feelings of care, concern, worry, feeling happy or comfort and, in critical times, fuelled by fear. Both the context of *Being-in-the-world* and the mood from which that is experienced at a given time, were illuminated to be both drivers and barriers to practitioners' capabilities in grasping patient presentations. Snapshot judgements were individualized and negotiated dependent on practitioners' and patients' capacity to cope with risk. Participants' experiences of risk often led to them identifying a learning need, or knowledge deficit, thus revealing an opportunity to develop and advance their ANP practice.

5.13.1 Conveyer belt environment – Thrown into the world

A Heideggerian interpretation is that the *Dasein* (existence) of each ANP is *thrown* into a revolving world of risk uncertainty, complexity and are *falling* as they are forced to *cope* with this risk on a daily basis. Dave states *"The world is revolving"* (DavInt1) referring to limited time and a constant "*patient flow*" (DavInt1/PhiInt2/SteInt1). The findings suggest that the phenomenon of risk is constantly changing according to place, time and perspective and thus, decisions taken regarding risk must be understood in this context. Indeed, within this context

opinions are formed and decisions regarding risk are made based on "*snapshots"* of time (DaviInt1/2/CatInt1/2).

"Being-in-the-world is the basic state of Dasein in which Dasein operate in the mode of everydayness" (Heidegger, 1962, p.86/59). The *everyday* subconscious of coping with risk is managed through what is *ready-to-hand* - an unconsciously present reality. This average, everyday coping is forced into consciousness when usual patterns or tools do not work – when they are *unready-to-hand* - or when there is insufficient understanding, or something is felt to be wrong or not known. On these occasions when the usual comfort or understanding is not achieved, Beth describes being "*forced to confront*" risk (BetInt1), moving from an everyday subconscious coping to a conscious mode of coping. Risk is an awareness of the "*possibilities"* of what might happen (KinInt1/WilInt2). Heidegger (1962) refers to the *unready-to-hand* as pertaining to something that is missing and thus becomes a focus of concern.

The "*conveyer belt"* (DavInt1/2, SteInt1) metaphor conveys the "*relentless flow"* (DavInt1/PhiInt2/SteInt1) and infers a constant pressing-on of time and lack of control. This can be likened to *thrownness* which Heidegger (1962) describes as being *delivered* over in the world without choice. Halting or slowing down the conveyer belt is necessary "*stop go back and reassess*" (SteInt1/2) but also quite *"harrowing"* (DavInt1) when you have an awareness of other potential risks that you may not yet have knowledge of. The conveyer belt can be related to Heidegger's fundamental notion of *temporality* in which time is temporal and constantly moving and furthermore to a loss of control and *falling*. This is coped

with by getting things done "*quickly"* and efficiently with a variable reliance on *Others.*

In discussing this *thrownness*, Heidegger (1962) states that *throw* implies not coming to a *stop* because *Dasein* is there now and gets dragged along in its *thrownness*. The analogy of the conveyer belt which keeps moving has strong connotations for the movement of time. Indeed, Heidegger refers to the present as "getting taken along", never arriving at any their ecstatical horizon of its own accord, unless it gets brought back from a lostness by a resolution" (Heidegger 1962, p.400/348). This can be described as falling which Heidegger refers to as being in the present: "Falling has its temporal roots primarily in the present whether in making present or in the moment of vision" (Heidegger, 1962 p.401/350). Making present can be reference to the snapshots or time-junctures of stopping to re-evaluate.

Risk is coped with alongside *Others*. How the *Dasein* of each participant views themselves is according to how they view their role, the role of others - such as junior and senior colleagues and patients - and how they perceive the dynamics. One either "*just gets it done*" himself (PhiInt1) or takes risk safely "*beneath the wings*" (WilInt1) of colleagues. Senior practitioners are aware of the need to support those less experienced, who may require the potential of risk to be revealed to them, "If it's still far off, its fearsomeness remains veiled" (Heidegger, 1962 p.180/141). With increased experience, the "*luxury"* (WilInt1) of support may be notably absent. This can lead to resentment, "*loneliness"* and "*isolation" (DavInt1)*. As Heidegger (1962) states, you can be with others and also be alone.

Working within an environment that "*values objectivity over subjectivity"* (TedInt1, WilInt1) leads to learning to "*jump through hoops*" (DiInt1) to give you "*more clout*" (TedInt1), as well as working around guidelines for the benefit of patients. Protocols, guidelines, rules, and current priorities – the "*golden goose*" (WilInt1) guides the practice in dealing with risk. Protocols are used to help support decisions, particularly when referring patients to *other* practitioners: "*He was red on the matrix…its binary, innit?"* (DavInt1). Safety-netting often involved referring patients on

On the occasions when perception of risk is based on subjectivity and in the absence of objective data to rationalize that judgment, Ted spoke of using "*tricks"* (TedInt1), such as when he coerced a patient into agreeing with what was perceived the safe course of action.

Strictly following guidelines without application or *"blindly following the rules*" (BetInt2) rather than interpretation for individual patients can "*restrict practice"* and lead one down the "*wrong pathway"* (SteInt2). Alternatively, it can lead to decisions that are not considered to be in the "*best interests"* of patients (BetInt2). The consequence of this may be exposure to new risk, such as unnecessary tests or hospitalization. Guidelines can also lead you down the "*wrong track"* (KinInt1). Referring to current priorities which change according to "*what is flavour of the week",* can make you "*hyper-aware"* and cloud your judgements (PhilInt1). Guidelines can be followed defensively to safeguard professional risk whilst exposing the patient to unnecessary risk. This may be seen as "*passing the buck*" (WilInt2) of risk by sending patients to hospital when there are also "*risks to hospitalisation*" (PhiInt1).

Heidegger's average *everydayness* can be related to the following guidelines without application *"an automatic process of putting a person on a conveyor belt, such as a specific chest pain pathway."* (SteInt1). Judgements regarding risk according to what *Others* (rules) say should question the *authenticity* of remaining true to one's experience, understanding, and expertise. Doing the correct thing is not necessarily the right thing and, furthermore, the "*easy thing"* is not always the "*right thing"* (DiInt1).

5.13.2 Patient Sharing

Each participant has his/her own *Dasein* and, thus, his/her own view of the patient unique to their perspective which differs according to power dynamics, communication, decision-making and this affects how risk can be managed. Perspectives of risks don't always correlate: "*patients can be anxious about a papercut*" (DiInt1) or being unable to meet expectations don't have a*" magic wand*" (AbiInt2/CatInt1). Heidegger refers to a primordial understanding which is *"taking a stand on your own Being"* (Heidegger, 1962 p.183/144). Thus, each participant takes a *stand on their own being* in terms of their approach to their role and their perspectives on patients. Patients may be seen as "*potential risks"* (WilInt1) or as a "*commodity",* passing down the "*conveyer belt"* like a "*little duck"* (DaveInt1) or as a "*customer"* who needs to be "*happy"* (CatInt1). There were paternalistic attitudes towards the patients with some ownership: "*that's what we do, we keep <u>our</u> patients safe*" (PhiInt1). In this stand of their own being, there is a question of *authenticity* of "*that's what we do"* or is that what *others* say or think we should do?

The patient/practitioner dynamic is dependent on the discourse as to whether, how, and to what degree risk is *disclosed* and*,* thus, revealed to patients; this ultimately affects the patients' perspective*.* This *stand* or perspective of the patient has implications as to how and if risk is shared with patients and the level of informed decision-making. This *discursiveness* of revealing or concealing and *disclosure* or *non-disclosure* involved variable techniques. Heidegger may refer to the *discursiveness* of "c*ranking up rapport*" (BetInt1) to get patients "*onboard*" (KinInt1) as *inauthentic idle chatter*. Similarly, "*shock tactics"* (TedInt1) used to steer the patient perception of risk may be considered *inauthentic.* In terms of sharing risk, patient capacity, communication, relationships, and trust were strong features. Indeed, Heidegger referred to a "co-state of mind" with others (Heidegger, 1962 p.181/142) whereby opinions need not align.

5.13.3 Care or Concernful

Care was an anomaly as to whether caring about the patient was a pre-requisite to being able to manage risk effectively. For example, Beth, in her first interview, described patient rapport as central to risk management, yet in her written reflections, this rapport was not evident and was contrasted by frustration towards patients. The multiple data sets revealed something that may have remained concealed if interpreted purely from the first interview. Dave denied caring as being a prerequisite to managing risk, stating that patients were commodities and a necessary part of him getting through his day while also giving his patients "100%". For Heidegger, *care* is defined in how *Dasein* is *being-towards*, *attending-to* rather than having emotional feelings of love or empathy. As a part of the concept of

care, Heidegger refers to the term *concernful as "*being alongside the ready to hand in the world*"* (Heidegger, 1962 p.402/351) and is what he describes as "the everyday mode of Being-in-the-world that is closest to us" (Heidegger, 1962 p.402/351). Dave's rejection of care in its traditional sense led to a deeper interpretation of the notion of care, not just for Dave's interpretation but also in the reiterations of interpretation for all the participants.

5.13.4 Coping with Risk

Risk is accepted as inevitable by all participants. The everyday awareness management and essentially "*coping"* with risk is core to the role of an ANP. Acceptance of risk for these participants is part of average-*everyday-coping* which, for the most part, they are not consciously aware of. This consciousness potential risk is forced into awareness when faced with an awareness of a level of increased risk beyond which they are comfortable with or when something is wrong, missing, different, not known or not understood. Heidegger (1962 p.106/75) refers to the world being "lit-up in the modes of concern" when the *present-at-hand* comes to *the fore.* Heidegger refers to "fear as a slumbering possibility of Being-in-the-world in a state of mind" (Heidegger, 1962 p.180/141).

To cope with risk must involve having an awareness, described as "*Keeping an eye*" (DiInt1/PhiInt1). This awareness can be *present at hand* when the risk is explicit "*happening right in front of me*" (PhiInt1) or *ready to hand* when it is potentially there in the background: "*I don't know what is going on in the waiting room*" (DavInt1). This includes being aware of others' ability to understand risk, such as patients themselves when safeguarding or referring to colleagues who may

not have an informed awareness of risk. Thus, examples of managing through anticipating risk were asking if colleagues are coping or "eyeballing" (CatInt2/DavInt1) the waiting room.

Behaviours to assist coping with risk included seeking more information and, thus, insight or understanding, and sharing the risk with others, such as patients themselves or other colleagues. "*Flag waving*" (DavInt1) was an example of sharing with colleagues, perhaps through asking advice, seeking support, or referring patients. Decisions regarding whether "the buck stops with me" (DavInt1) or "passing the buck" (WilInt2) of risk to others by *signposting* can "*stifle practice if never carrying risk yourself*" (DiInt1). If risk is not passed on, then it is shared with the patient through *thorough* safety-netting, so things don't "*slip through the net*" (DiInt1). Thus, one should "*broaden your net*" (DiInt1) according to individual circumstance.

Risk as a concept is temporal in so much as that it is always set in the future; it is a projection pressing into possibilities (Heidegger, 1962 p.183/144). With an awareness of risk, there is a sense of a future potential possibility of what may or may not happen. This raises the questions of potentiality verses actuality. Risk is always a potential on becoming actual, it is no longer a risk but reality. Whether risks become realty does not negate its value. Rather, it is having the ability to project possibilities as probabilities and safeguard against risk. Thus, participants referred to "*measured risks"* according to probability (DiInt1).

Risk as understood from the perspective of *Dasein,* may be a fear of a risk to self: "*I am accountable*" (CatInt1/SteInt1), "*I may be up in front of the NMC*" (PhiInt2), "*it's my registration on the line*" (DavInt2). It may be the risk to the

patient: "*they could die*" (WilInt1). Thus, risk can only be understood from the perspective of an individual *Dasein.* There is conflict when these perspectives of risk do not align, such as when there is concern for a patient who is not concerned for themselves. Heidegger talks about *fearing for Others:* "the Other for whom we fear, near not fear at all on his part". It is precisely when the other is not afraid and charges recklessly at what is threatening him that we fear the most for him" (Heidegger, 1962 p.181/142). However, if the decision is rationalised and the patient *autonomously* and with *capacity* chooses not to comply then there is a sense of comfort: "*I can sort of live with that*" (DiInt2).

5.13.5 Moods – Fuelled by fear

Coping with risk is done so through moods, such as being *scared*, because it "*keeps you sharp*" (Di Int1). Sensing the world for the participants was how they took in subjective information based on a feeling or sense that they had towards a patient or situation. Detection of risk arises feelings of worry, concern, and not being happy. Conversely, a sense of safety leads to positive feelings of being "*happy", "satisfied", "confident"* and "*self-assured".* The latter may be considered "*ego*" or "*back in the groove*" (AbiInt1) or having that "*zing*" (PhiInt1). Risk-coping behaviours that either reduce, pass on, negate, or eliminate risk, such as stabilizing patients or referring patients on can transfer negative feelings of angst to positive decompressive moods, such as a sense of "*comfort"*, "*relief"* and "*resolution"*.

These moods affect how risk is approached and can both help and hinder coping with risk. Feelings of competence and confidence at one end of the

spectrum spans to "*incapacity*" and being "*overly risk adverse*" (BetInt1) at the other end.

The exhilaration or "*ego*" (AbiInt1) of being "*on the edge"* (DiInt1) at the former end of the spectrum leads to questioning as to whether their approach is "*cavalier"* (BetInt1) risk taking. Somewhere in the middle of this continuum can also be more innocuous but potentially dangerous. Moods, such as boredom or lack of care, or an attitude that is "*laisser-faire*" (BetInt1) may lead to a certain state of complacency in which one may "*miss something*" (DiInt1). And this, in turn, can lead to "*flatlining*" (PhInt2) and, ultimately, not advancing one's own practice. In what Heidegger refers to as *bad moods* "Dasein becomes blind to itself, the environment with which it is concerned veils itself, the circumspection of concern gets led astray" (Heidegger p175/136).

Heidegger's interpretation of when the "*shit hits the wall*…" (DavInt1) may be found in the following quote: "If something threatening breaks in suddenly upon the concernful Being-in-the-world…fear becomes *alarm*" (Heidegger, 1962 p.181/142). Heidegger refers to how underlying concern can lead to fear or terror, which he states, "bewilders and makes us "lose our heads" *(Heidegger, 1962* p.180/141). This may refer to the reference to being "*paralysed by fear"* (SteInt1).

Participants describe being *"on the edge"* (AbiInt1, DavInt1, DiInt1) and how they sometimes manage risk "*by the skin of your teeth*" (DiInt1). On the subject of fear Heidegger states: "*That which* fear fears *about* is that very entity which is afraid – Dasein. Only an entity for which its Being this very Being is an issue, can be afraid" *(Heidegger, 1962* p.180/141). Emotions can "*alert and trigger action*

responding to risk through adrenalin and fear" (AbiRef2). *"Anger gave me some zing; made me zip around the department getting things done." (PhiInt2)* According to Heidegger "Dasein can, should, and must, through knowledge and will, become the master of its' moods" (Heidegger, 1962 p.175/136). Phil referred to "*embracing"* fear despite the uncomfortable nature of it (PhilInt2).

5.13.6 Information seeking: Revealing that which is Concealed

Risk and patient safety was managed from a "*holistic assessment*" (AbiInt2/BetInt2/DiInt1), using both objective and subjective information, a picture is built in terms of an understanding of a patient presentation or situation. In order to manage risk as safely as possible, there is often a need for more information to gain a holistic picture. This may be to prove or disprove an initial impression of a situation, sometimes in terms of a "*check list"* to ensure no potential has been "*missed".* This involves picking up cues as to what *"rings in your mind".*

From an initial impression of a patient situation potential risk may be identified through a feeling that *"something is missing"*, and this leads to searching for the "*missing piece of the jigsaw"* (CatInt2), and a "*click"* (AbiInt1/DiInt1/2) when "*it all… becomes clear*" (DiInt1). From the perceptive of the Dasein of the participant, targeting what is perceived to be relevant information aids understanding. This process can be subtle or innocuous, seeking out a concealed or "*veiled"* worry or fear at the back of one's mind needs to be brought closer to the fore and revealed. Participants described a strong desire seek confirmatory reassurance that nothing has been missed: "(I) *don't want to miss the curveball*" (PhiInt2) or the "*golden goose*" (WilInt1).

This "*checking process"* (AbiInt1) implies seeking verifying confirmatory objective information, such as blood tests, x-rays clinical observations (such as blood pressure or pulse), electrocardiograms. This objective information is combined with subjective information such as the look or feel of the patient. Enabling a discourse in which patients can disclose or reveal necessary information was crucial to all participants when managing risk. Beth described this as creating a *"safe space"* (BetInt1). Heidegger may refer to this as a *clearing* in which entities are enlightened and seen.

All participants described a strong visual element. Describing "*looking", "watching"*, "*eyeballing",* through which they were able to have a vision and see beyond that which presents itself as *present-to-hand* and being able to *see* or *sense* a potential beyond that which is obvious. This "*click"* can follow a "*visual clue"* (AbiInt1). Intuition was referred to by many participants and is described by Heidegger as a form of "Seeing" of "that which relates itself to them [objects] immediately, *and which all thinking as a means has as its goal*" (Heidegger, 1962 p.410/358).

A combination of subjective and objective knowledge was used to interpret patient presentations. This is referred to by Steve as a "*tool box for diagnostic reasoning"* (SteInt1). Subjective feelings are used to fill the gaps where the picture is incomplete. Heidegger refers to seeking a *clearing* of trees to reveal certain truth – what Heidegger would term Alethia. For these participants in terms of experiencing risk and patient safety, rather than one truth or one perspective, there are multiple possibilities, each with their own probability. Heidegger (1962) articulates truth as *disclosure* or *unconcealment*. Truth belongs to *Dasein* and

Dasein can be can be both truth and untruth (Koskela, 2012). The participants describe, in various ways, how knowledge, understanding or interpretation can "*veil"* or *"conceal"* an alternative truth or understanding. This is described a getting stuck in a "*pigeon hole"* (SteInt1) or "*going down a path*" (SteInt2). This assumption of understanding or "*conformational bias*" (WilInt1) where "*what you see supports that picture*" (KinInt1) can conceal and leave participants blind to other potentials. It is important to "*remain open minded*" and to think "*broader"* (KinInt1) than the initial diagnosis. Thus, rather than focusing on the *clearing,* one must look to the edges and beyond into the trees at those possibilities that remain concealed.

Heidegger refers to a *sense of ecstasis* in which Dasein gets *carried away* to *possibilities* of concern:

> *The present is not only brought back from distraction with the objects of one's closest concern, but it gets held in the future and in having-been. That Present which is held in authentic temporality and which is thus authentic itself, we call the 'moment of vision'.* (Heidegger, 1962 p.387/338)

5.13.7 Knowledge Comfort zone: *Fore-having, Understanding, Interpretation*

Everyday coping with risk is facilitated and enabled by an underlying knowledge. This was referred to by Di as a "*baseline"* of knowledge (DiInt1) and this knowledge enables one to be familiar with the norm. This knowledge-base is made up of formal knowledge from training and reading, to less formal knowledge from experience and more subjective *knowing.* Even formal knowledge is simply "*facts as we know them"* (SteInt1). It is through this *fore-having* that a working

understanding and ultimately interpretation of experience is achieved. This *fore-structure* of "*loads of stuff…sitting in my head…some of it lost forever"* (DiInt2) perhaps by *"dribbling out the back door" of one's mind"* (AbiInt2). This knowledge-base can provide comfort, or as some referred to it, being presented with the familiar – their "*comfort zone"* in which they are comfortable, happy and their "*coping"* with *everyday* risk is so close it becomes "*transparent"*. "I knew instinctively, I looked at the knowledge later" (AbiInt1).

Transparent coping of the *everyday* is through a subconscious interplay between this everchanging knowledge base and experiences, past, present and potential future. Heidegger would refer to this preconceived knowledge as the *fore-structure* in which *fore-having* can afford foresight. Di refers to the "*click"* of suddenly "*knowing"* something in the moment by relating it to previous experience, describing it like a light switching on "*it all came back to me*" (DiInt2). This applying of what is present to the knowledge base could be described as *fore-structure*. How this knowledge is accessed is multi-faceted and these different factors can affect whether knowledge is revealed or concealed. The *disclosure* of one aspect of knowledge that forms a working diagnosis can then conceal other potentialities; thus, the caution to remain open minded.

Access to knowledge is dependent on both the forefront and back of the mind. This requires "*burrowing back into your mind*" (DiInt2). This is affected by time with regard to what has happened most recently, or perhaps to experiences perceived to be significant, such as serious or potentially serious near misses. Knowledge is accessed according to mood, i.e. Phil's scattergun approach when disordered unfocussed (PhilInt2). Feelings of confidence enable one to access their

knowledge and to move outside of a knowledge "*comfort zone*" (PhiInt1/2). It can also refer to sense making when trying to achieve an understanding of a situation in which they feel uncertain about or there is an unknown. Risk was sensed through a feeling of concern: not being "*happy*", "*worried",* a feeling there is "*something more, something else" "something missing".* Thus, when what is being experienced does not fit or cannot be understood according to the existing knowledge patterns or boxes of knowledge, it is something different and, therefore, a learning opportunity.

Understanding is grounded primarily in the future (whether in anticipation or in waiting)" (Heidegger p401/349). In order to achieve an understanding, there is the pre-requisite of care, which Heidegger would refer to as *being towards*. Indeed, Heidegger explores the "meaning of the way in which circumspective concern becomes modified into theoretical knowledge of what is present at hand within-the-world" (Heidegger, 1962 p.403/352). Seeking an interpretive understanding can be fuelled by fear. Fear can fuel anticipatory alertness and drive reactions to cope with risk and patient safety. Yet Heidegger writes that "Fear closes off our endangered Being-in, and yet at the same limits us to see it, so that when fear has subsided, Dasein must first find its way about again" (Heidegger, 1962 p.180/141). Mistakes or near misses can make you "*fastidious"* (KinInt1) to your approach to future situations.

Participants described reflecting, post-incident, in terms of the "*drive home"*, or "*sleepless nights"*. This was often triggered by fear. For Heidegger, "Circumspection sees the fearsome because it has fear as its state-of-mind" (Heidegger, 1962 p.180/141). Circumspection (reflection) can be precipitated by

strong moods of care or concern: *"that touched me on a human level"* (CatInt1), or by unresolved feelings of not understanding. In addition, a feeling of not providing optimal care in terms of managing risk (*"I failed him")* can lead to a period of reflection. It is these feelings of circumspection through concern that "diverts itself specifically into a just looking around… 'inspecting', checking up on what has been attained, or looking over the 'operations' which are now at a standstill" (Heidegger, 1962 p409/358). Thus, to be safe one needs to keep a *"critical eye"* on one's own practice (AbiRef1).

Heidegger describes basic understanding as coping; as a knowing-how to use equipment in the world in a way in which is automatic. For example, Di refers to her limitations when she says: "*we all have a bag and that's not mine*" (DiInt2). Heidegger relates *understanding* to *"Dasein's own potentiality-for-Being and it is so in such a way that this Being discloses itself what its Being is capable of"* (Heidegger, 1962 p.184/144). For Heidegger, u*nderstanding* should not be confused with cognitive interpretation, rather *understanding* is a basic flow of coping with the everyday world. This relates to the participants' descriptions of reflections on their knowledge while dealing with risk in the present.

Interpretation as the next step of understanding can therefore align with participant descriptions of reflecting on incidents on their own or with colleagues, or on that drive home when seeking for interpretative meaning, learning or missed knowledge of a situation. Heidegger would describe these reflections as *circumspection.*

A potential response to "that which threatens has the character of something altogether unfamiliar then fear becomes *dread*" (Heidegger, 1962 p.182/142).

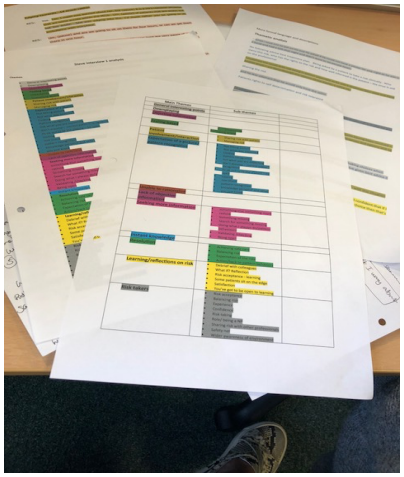
Rather than learning from *"glitches"* (AbiInt1), one may choose to "*avoid"* experiences that are outside of one's comfort zone: "*It's really put me off gong there*" (DiInt2). The advancement of practice is in embracing and facing fears of that which is not known, accepting the inevitability of risk and inherent uncertainty and taking "*safe"* risks based on probability through using *Others* and available resources. Moreover, as Heidegger would term, equipment that is *present* and *ready to hand*. Reflection, learning and ultimately moving from *understanding* to *interpretation* is what leads to expanding experience and knowledge base to drive practice forward out of *Dasein's* comfort zones and thus avoid stasis or, as Heidegger would term it: "unreflecting devotion to the 'world'" (Heidegger, 1962 p.175/136).

5.13.8 Summary

This chapter outlined an interpretation of each participant's individual *lifeworld*. This was followed by a collective interpretation of the worldhood of the lived experience of management of risk and patient safety of the ten participants, which was interpreted through the Heideggerian philosophical lens under the following headings: Conveyer Belt Environment (*thrown into world, lifeworld, worldhood*); Coping with risk (*coping, falling*); Patient sharing (*being-with, others, discourse*); *Moods – fuelled by fear (care, concern-towards, fear*); Seeking Information (*Revealing what is concealed - understanding,*); Knowledge Comfort Zone (*forehaving, understanding to interpretation*). The following chapter addresses key areas from the findings of the study and places these findings within the context of

the current literature. Figure nineteen below is some reflexivity upon my presence and impact during the process of analysis.

June 2018. My foot is in the picture….



I noticed in creating this visual representation of the cycle of layers of analysis that my foot was in the picture. I resisted to crop and clean up the image. In choosing interpretive phenomenology, I have chosen to not bracket myself out. I am part of the analysis, I am present, with my foot under the table and it is my shared interpretation that is fundamental to how these findings are made sense of and interpreted. It is my care towards the subject that this research design was created it is my being-with the participants listening, responding, creating the space in which to achieve rich meaningful narratives. I am part of the picture. I exist. I am Dasein.

Figure 19: Reflexivity Box 5

Chapter Six - Discussion

6.1 Introduction

This chapter is a critical discussion of the findings in the context of the wider literature on ANP management of risk and patient safety. It focusses on the areas of new knowledge or advancement of understanding achieved and areas of contention raised by this research which form the structure for this chapter. These areas are: redefining risk; concept of care; instinct fuelled by fear; ethics of risk; and comfort zone of knowledge.

6.2 Redefining Risk

Patient safety and managing risk was an issue of heightened focus and concern for the ANPs within this study. Indeed, from the literature, risk is recognised to be high on current political and clinical agendas (Burton and Wells, 2016; Hutchison, 2016; DH, 2013, 2012, 2010, 2002; Klein and Pulliam, 2009; Pearson, Steven and Dawson, 2009). For these participants, there was an underlying acceptance that coping with and managing risk was an everyday experience and essential to their role. Indeed, Mythen and Walklate (2006) refer to risk as a ubiquitous issue that stretches over a range of social activities, practices and experiences. This aligns with participants' descriptions of risk being everywhere, multileveled, and negotiated though varying perspectives.

The concept of risk has been defined and understood from multiple disciplines (see Chapter Two). However, in the literature, there is little from the perspective as experienced by todays ANPs as they advance into new areas. Whilst

risk can be framed, calculated or measured through traditional positivist conceptions, contemporary risk literature recognises the emotive component of risk. The subjective experience of risk does not involve numerical data (Riva, 2012). Risk is closely related to trust and has been said to be confused with fear (Llera and Newman, 2014). It is clear that this new understanding of risk does not fit classical definitions of risk which refer to expectations, probabilities and potential loss (see Chapter Two).

The findings align with contemporary risk theories that acknowledge the context of risk, such as the notion of a *risk society* as described by Beck (1992) and Giddens (2002). There is also an application of the findings to a cultural understanding of risk as a social invention which relates to Foucault's (1991) theory of the *language of risk* governing our conduct. A key finding is the unveiling of negotiated risk. Indeed, a core factor, adding complexity to risk in this context, is that patients are increasingly actively involved in their health decisions. Participation in one's own health means one must consider multiple perceptions of risk. The findings of this research offers a new understanding of risk which recognises a complex interplay of negotiated risk between different factors and players in which neither the ANP nor the patient are passive recipients, but potentially are active players.

The ANPs in this study associated risk with a "*probability"*, "*likelihood"*, "*concern"* and "*worry"* about something that may compromise patient safety, at a particular moment in time in an ever-changing context. Berry's (2004) simplified definition of risk identifying two main elements as probability and a hazardous aspect does not address the complexity of perspective, context or indeed,

temporality of risk, as described by the ten participants in this study. Therefore, these findings offer a unique understanding of risk as experienced by ANPs in acute settings today.

Participants experienced risk according to their individual context of not only the situation but also in the context of their knowledge, experience and emotional state. Rhodes (1990) distinguishes between understanding risk as the product of individual cognitive decision-making and the view risk is the product of social interactions. This can be applied to the practitioner's individual cognition or analysis of risk and from their understanding of risk according to their context on a sociocultural level. These findings indicate that experiences of risk cannot be isolated to the participant's individual cognition; rather it was a socially constructed experience that cannot be separated from the ANP *lifeworld*. Indeed, a decontextualized understanding which separates a person from their world concurs with a Cartesian understanding of subject and object. Furthermore, separation of understanding risk from either a psychological perspective or a socio-cultural one does not align with Heidegger's view of *Dasein* as already *Being-in-the-world*.

The participants are *thrown* into the *lifeworld* of managing risk and patient safety and in their *falling* as they are *absorbed* in their *everyday* world of *coping* with risk. It is through the Heideggerian lens that this study offers a unique understanding of risk derived from the lived existence of these participants as:

> A temporal awareness of perceived possible compromise to safety to either patient or practitioner in which a potential harm is anticipated as a probability. This potential arises from a patient presentation or clinical situation in which the practitioner has a sense of concern or fear of (i) actual threat to safety, or (ii) that something is unfamiliar, unknown, or not fully understood that may be a concealed threat to safety. This leads to a need to

further comprehend, act upon the risk and resolve the risk, to ultimately achieve a higher level of safety at that moment in time.

For these practitioners, the experience of managing risk is a temporal, continual balancing of probabilities between multiple presenting risks and potentially unknown future risks. The perception of risk can arise not only out of the presenting situation but also from the practitioner's knowledge, perceived ability, confidence and capacity to cope with the presenting risk at a specific juncture of time. Experiences of managing risk and patent safety often identified a learning need and an opportunity to develop and advance practice. The proposition of a new definition of risk based on the experiences of ten ANPs may be questionable. Indeed, the commonality of this experience beyond these participants cannot be certain, however the rich thick data essences has shed light in this area of practice that can form the basis for further research.

The participants discussed risk in terms of "*probabilities"* (PhiInt1/2, SteInt1/2) and made decisions based on what is "*reasonable"* (AbiInt1/2, SteInt1). The participants discussed "*weighing up"* possibilities (AbiInt1), going through a "*checklist*" (PhiInt2) of making sure nothing is "*missed"* and working out the likelihood of "*worst case scenario"* (TedInt1, WilInt2). This aligns with the psychometric understanding of risk as a common-sense estimation of risk probability judgements upon the range of possible risks perceived in their environment in which a calculation of the likelihood of potential harm is made (Bourne and Robson, 2009).

This research adds a key component of risk of a feeling that something is missing or not yet known or understood. In Beck's (1992) *risk society*, unknown risks can have greater significance than known ones. For the participants, perception of unknown risk was based on a subjective feeling of concern or worry that was furthermore compounded by a sense of potentially missing something. Slovic (1987) contends that perceptions of risk are informed more by qualitative characteristics than by quantitative ones, indeed fear of missing an unknown risk was a key driver for mitigating, safety-netting and managing risk.

The participants' perception was frequently based on the initial look of a patient. This subjective understanding of what the patient *"looked"* like also aligns with a psychometric approach to risk, wherein researchers tend to find that a concept is based on perception rather than fact (Bourne and Robson, 2009; Wilkinson, 2006). The *"look"* was a subjective visual perception described by participants was an important component of assessing and managing risk and often used when limited time or limited objective information is available. However, the lack of an objective basis emerged as a challenge to the participants in their approach to managing perceived risk. It is important to note that for these findings, outcomes were not measured. Further exploration of this "look" and its relation to risk is required. Subjective perception of risk challenges both subjective and objective investigation. Whether the risk becomes a reality or not does not necessarily negate the risk.

The duel view of the social representation theory which understands risk as a social process as well as one of rational decision-making (Zink and Leberman, 2001), aligns with the findings of this study. In this theory, risk has its basis in social

relations involving partial and incomplete discourses and decisions are made privileging some ideas/relationships and ignoring others. An understanding of the socio-cultural context of clinical decisions and the degree to which they are affected by *Others* was fundamental to how risk was experienced. Participants described sharing risk with others, either the patients themselves or colleagues, particularly valuing the opinions of seniors. Whether "passing the buck" (WilInt2) or "buck stops with me" (DavInt1), managing risk involved a social process through in which communication facilitates rationalisation and negotiation of the risk. However, this external social interactive process happened alongside or often after an internal judgement has been made.

Participants described having to rationalise their subjective judgements in an objective environment in order to ensure professional credibility and to keep registration and practice safe. Plattner, Plapp and Hebel (2006) point out that attempts to mitigate risk and enhance safety has led to a rise in evidence-based standards and guidelines and thus a healthcare environment dominance of objectivity over subjectivity. Nevertheless, the reality of practice for these practitioners' subjective judgements such as the "look" has a clear importance when managing risk.

The participants described how the challenge of coping with risk is heightened when their perception of risk could not be shared with others. Indeed, the findings reveal that awareness of risk and how it is interpreted, varies according to perspective that of the patient, practitioner or others i.e. patients who are anxious about "*paper-cuts*" (DiInt1). Consideration of the multiple perspectives of risk is imperative as for these practitioners always has an inescapable component

of subjectivity. For example, participants described how less experienced practitioners may either see risks in everything they do resulting in "*sleepless nights"* (CatInt1/2) or not have the experience or knowledge to perceive risks that can be seen by more experienced practitioners (PhiInt1/2).

The findings of this research revealed that participants perspective embodied many factors in their decisions regarding risk. Management of risk and patient safety was dependent on knowledge, experience and perceived capacity to cope (of both practitioner and patient). This perspectival understanding of risk not only aligns with Bourne and Robson's (2009) conception of risk, but also is fundamental to the Heideggerian philosophical belief that all entities are understood from the perspective of one's own existence. Thus, risk is perceived and experienced from the perspective of *Dasein* (existence) (Heidegger, 1962) of the participant, or the patient experiencing it.

The participants referred not only to patient risk but also professional risks with regard to their registration. Rycroft-Malone *et al.* (2008) pointed out that although most nurses view the expansion of traditional nursing roles favourably, they also have concerns in terms of liability and vulnerability. An implicit assumption of this enquiry may have been that the risk being investigated was of patients. However, the findings reveal another dimension of risk, that of the practitioners themselves.

These findings reveal a complex of interrelation of risks of both patient and practitioner that requires a negotiated balance between the two, involving careful consideration of the patient's perspective and informed choices regarding risk. Ethical questions may be raised as to how concern about professional risk may

affect the practitioner's approach to providing care based on patients' best interests.

Arguably when the concerns about risk for professional registration conflicts, or outweighs the concerns of patient safety, then this may lead to defensive practice; an association that has been identified particularly after errors or near misses (Gary, 2013; Meurier, Vincent and Parmar, 2008). Defensive medicine refers to practitioner performing treatment or procedure to avoid exposure to malpractice (RCN, 2008). Such practice potentially exposes patients to over-investigation or unnecessary hospitalisation, which have not only financial implications but clear risk to patient safety in terms of invasive procedures, radiation and iatrogenic morbidity (Ghosh *et al.*, 2012; Sajjanhar, 2011; Haycox, Bagust and Walley, 1999). This was the case in Ghosh *et al.'s* (2012) study which identified a three-fold increase in CT scans when the NICE head injury guidelines were followed. Indeed, it was a consensus amongst the participants of this study that following guidelines "*blindly"* (BetInt2) can lead to safe and defensive practice, with the inadvertent consequence of over-investigation. Furthermore, defensive practice increases healthcare costs and leads to degradation of practitioner/patient relationship (Sekhar and Vyas, 2013). The participants referred to having to manage the expectations of patients requesting unnecessary tests. Phil pointed out: *"patients think that a test will make their symptoms get better"* (PhilInt1). Rolfe and Burton (2013) in their systematic review looking at reassurances after diagnostic testing of patients with low probability of serious illness, found that diagnostic tests did little to reassure patients, decrease their anxiety or resolve their symptoms, although it was found that the tests may reduce further primary

care visits (HEE, 2017; NHSE, 2016; NICE, 2016; Walsh, 2001; Woolf *et al.*, 1999).

It is important to consider the wider implications of how practitioners are experiencing and coping with risk regarding how they are educated and supported in practice, both in terms of the consequences to patient safety and to the wellbeing of practitioners themselves. If defensive practice is a by-product of practitioners struggling to cope with risk safely, this will ultimately perpetuate the cycle of loss of patient confidence and trust, particularly in the wake of increasing public accountability. Thus, the insights of this research whilst not generalizable, indicates further research into this area is needed to understand the processes involved when managing risk and safety.

Ideals of standardisation within medicine have led to methods such as guidelines and protocols that aim to create predictability, accountability and objectivity (Timmermans and Berg, 2003). Public preoccupation with risk has been attributed to loss of trust of professional expertise (Ilangaratne, 2004). The lived experience of managing risk for the practitioners in this study is associated with a heightened awareness of their accountability and the requirement to be transparent, an association identified by Trinder (2008).

Traditional approaches to managing risk and patient safety in practice are policy-driven evidence-based guidelines, such as clinical decision rules which are unquestionably vital for safe, quality, cost-effective, standardised care (HEE, 2017; NHSE, 2016; NICE, 2016; Walsh, 2001; Woolf *et al.*, 1999). Evidence-based guidelines aim to increase effectiveness, minimise risk, avoid unnecessary testing and can provide comfort and safety for practitioners (Snyder and Weinburger, 2014). From the perspective of the participants, risk to their professional self was

exposed when these guidelines were interpreted or even not adhered to when it was perceived to be in the best interests of the patients. Gary (2013) wrote how nurses' practice in the interest of preserving their professional registration with an awareness that to step outside the boundaries of hospital rules and protocols, is putting careers at risk.

Several authors have highlighted the conflict between practice guidelines and nurses meeting specific patients' needs or clinical situations (Benner, Hooper-Kyriakidis and Stannard, 2011; Kramer and Schmalenberg, 2008; Hutchinson, 1990). It has been reported how nurses sometimes go beyond standard practice guidelines or find *work-arounds* to achieve what they believe is best for the patient (Benner, Hooper-Kyriakidis and Stannard, 2011; Stewart, Stansfield and Tapp, 2004; Berner, Ives and Astin, 2004). If risk and safety is to be managed effectively, this has clear implications for policies or guidelines to be applicable to the reality of practice.

Naylor *et al.* (2016) referred to an implementation gap between policy-driven strategies to enhance patient safety and what actually happens in practice. The findings from this research go some way towards illuminating this gap. The participants spoke of the pressures and heightened awareness of what was the current "*Golden Goose"* (WilInt1) not to miss, often following an adverse incident with a period of time of "*posters in the toilets that you learn to ignore*" (PhiInt1). Thus, despite an awareness of the policies or current focus of risk and safety, these guidelines are not adhered to. Non-adherence to guidelines and policy was a finding of Rasmussen's (2012) study. For the participants, adherence to guidance was variable. Steve spoke of the liberty of "*tearing up protocols"* to allow a more flexible

approach to managing patients (SteInt1). The literature attributes non-adherence to non-linear processes, or for the perceived benefit of patients, patient preference, and other contextual factors (Ghosh *et al.*, 2012; Rasmussen, 2012). Whilst acknowledging evidence-based guidelines are the foundation for best practice and safe care, Gary (2013) points out that this may not be available or realistic in certain situations. Joo and Huber (2014) argue that nursing decisions often involve uncertainty and risk which cannot be managed purely through guidelines. For the participants of this study, effective coping with risk involved an acceptance that there are multiple approaches, multiple options of possibilities that need to be considered for the benefit of the patient.

For the participants in this study, working within protocols was described as doing the correct thing and was considered a *safe* course of action for both the practitioner and patient. Guidelines proved to be a reassuring "*back up"* (TedInt1) and "*tool"* (SteInt1) or *"trick"* (TedInt2) used when working in an environment that values objective certainty: "*its binary, innit*?" (DavInt1). Thus, for these participants, there can be conflict between the professional safety, rationality and transparency of working within guidelines and the discomfort of perceived risk of working outside of guidelines for the perceived benefit of patients.

Arks (2006) study found that both novices and expert nurses prefer non-analytic processes of diagnostic-reasoning. The practitioners also commented that doing the "*correct thing"* was not always the "*right thing"* (BetInt1, CatInt1), indicating that the protocols and the guidance needed to be interpreted according to the context of the situation and the patient. Rasmussen's (2012) study identified that guidelines were worked around and improvised as staff struggle against

organizational constraints, unrealistic, conflicting priorities and protocol ambiguity. However, Rasmussen's (2012) further findings that practitioners were detached from protocols was not entirely the case with ANPs in this study, who used the protocols to support their decisions in their environment with a caveat of correct application to the context of individual patients.

Working outside of protocols was, at times justified as in the "*best interests of patient"* (DiInt1, SteInt1/2). Thus, guidance was interpreted and applied to individual patients and their situations. There was evidence in the literature that decisions can be more comprehensive when non-linear processes are used alongside linear protocols and guidance (Phillips, Stargatt and Brown, 2012). Some studies show evidence that linear protocols are only part of the picture of how risk and safety of patients is managed by ANPs (Phillips, Stargatt and Brown, 2012). To interpret or to work outside guidelines is to take a perceived risk: to the patient, organisational and professional liability potential.

The participants in this research described the freedom of working *around* protocols as opposed to the restriction that conforming with guidelines can impose. A number of studies have identified that experts transcend the reliance on guidelines that are typical in novice nurses. Riley (2005) argues for liberty against what is described as a growing tendency for conformism. However, despite increasing measures put in place to regulate practice in the area of risk, the findings from this study demonstrate that practitioners are not necessarily conforming. An intentional act of breaking the rules in order to serve the greater good relates to the term *positive deviance*. Positive deviance is intentional and honourable behaviour that departs or differs from an established norm and contains elements

of innovation, creativity, adaptability and by its nature involves risk for the nurse (Gary, 2013).

Carayon (2016) points out that systems and processes that are put in place to enhance safety can introduce new harms such as over investigation; this was seen in the findings of Ghosh *et al.*'s (2012) study. Indeed, imitating the acts/beliefs of others and not considering their own beliefs about what is actually true can lead to endless repetition without opportunity for improvement (Nys, Denier and Vandevelde, 2007). Cummings, Longo and Rioux (2012) referred to breaking free from the deadlock of conformism to open up a space for new ideas to be reasoned. Indeed, it has been argued by some that the focus on evidence-based medicine has led to a disregard of creativity and intuition that is necessary in today's clinical uncertainty (Engebretsen *et al.*, 2016; Greenhalgh, Howick and Maskrey, 2014; Greenhalgh, 2013). It is the contention from the findings of this research that experienced practitioners, on occasions, are managing risk though a creative and intuitive application of guidelines.

It emerged from the findings that risk is based on balancing probabilities of multiple adverse potentials and therefore there is not a predetermined singular path that can wholly be the answer or truth in dealing with risk in every situation. Thus, risk management cannot be reduced purely to protocol without the input or application of judgement, perspective from the practitioner, patient, and socio-cultural environment. Rather than a certain correct way, the participants referred to doing what was most "*reasonable"* given the context of the situation. Guidance rules were referred to as being "*worked around*" (PhiInt1/2).

Strict adherence to guidelines may be related to Heidegger's concept of the *inauthenticity* of following rules of *Others* against one's own authentic understanding: "the common sense of the '*they*' knows only the satisfying of manipulate rules and public norms and the failure to satisfy them" (Heidegger, 1962 p.334/288).

In summary, for the participants in this study, clinical judgements made regarding risk were done so within a context according to a moment in time. Risk is interpreted from multiple perspectives, and the risk itself may be to that of the patient, the practitioner themselves, or both. An understanding of risk unique to the ten ANPs in this study is proposed. Risk is inherently uncertain. Linear guidelines were interpreted and applied with consideration to the patient's best interests. Risk is managed through a balance of probabilities of multiple potential risks and negotiation between the varied perspectives of patient, practitioner, and the social-cultural context that they are existing in, at that moment in time.

6.3 Reconceptualizing Care

For these participants, a key element of managing risk and patient safety is a *care* or an intention of *concern-towards* patients that guided their practice. Nursing has a long association with caring (Ronald *et al.*, 2016; Paley, 2002; Watson, 1999), however, its' specific role in the context of risk and patient safety is limited within the literature. The findings of this study offer an insight into the concept of caring related to managing risk, that does not wholly align with the traditional sense of caring, historically associated with nursing.

For these participants, care or concern-towards was the position from which risk was sensed, understood, interpreted, and shared with the patient. This *concern-towards* happened within spectrum of care ranging from an emotional connective feeling towards the patient through to a sense of duty, purpose, role and professional responsibility, according to context and time. At the latter end of this spectrum, Dave, whilst showing a care and concern for his patients "he was *my* patient… he could have been a friend of mine…" (DavInt1) conversely also claimed that he viewed his patients as a "*commodity"*, as a "*way to get to the end of the day"* (DavInt1). Conversely, Beth declared patient "rapport" (BetInt1) to be central to how she managed risk in the first interview and subsequently referred to experiences of managing risk without that same rapport in a written reflection and the second interview. Indeed, variations of *care* arose not only between participants but also within the data sets of both participants. Indeed, it would appear iterative data collection and interpretation through a Heideggerian lens enabled a deeper interpretation of the phenomenon.

These variations lead to questioning within the analysis of the findings as to whether caring (in the traditional sense) is an absolute pre-requisite to managing risk for these practitioners. The nursing dimension of the ANP role denotes the privilege of decision-making regarding patient safety. Arguably, participants who did not view safeguarding patients as a caring act may be a consequence of environmental pressures impacting therapeutic relationship. Potentially, in another environment with different pressures, the findings may have revealed different results.

Caring is considered an aspect of humanity closely associated to nursing and the *essence* of nursing practice (Ronald *et al.*, 2016; Princeton, 2015). With the professionalization of nursing and development of roles such as ANPs, it is important to consider if concepts such as care remain at the definitive core of nursing. Notably, care was a later addition to the Chief Nursing Officer for England (CNOs) "5CS for nursing": compassion, competence, communication, courage, and commitment, thus showing the CNOs belief that the profession of nursing can be defined and strengthened by focussing on these values (6Cs for nursing) (Cummings, 2012). This re-focusing on caring would have been impacted by the Francis report (2013) which called for a structure of fundamental standards and improved support for caring, compassionate and committed nursing. Indeed, this report stated all nurses must act first and foremost to care and safeguard patients, thus caring in modern parlance provides nurses with a framework to value and respect patients. The findings from this study are based on the perspectives of these participants, whilst cannot be generalised, potentially opens new horizons of enquiry with regard to how caring is conceptualised in the context of managing risk and safety for today's ANPs. Further investigation to reveal how ANPs advanced medical model education and training may have had an impact on their concept of caring would give greater insight.

Definitions of care tend to centre around the nurse-patient relationship. Watsons (1999) theory of caring focuses on the holistic and authentic nurse-patient relationship, in which care is "the moral ideal of nursing whereby the end is protection, enhancement, and preservation of human dignity" (Watson, 1999, p.29). Traditional definitions of caring in the nursing context are feelings of

sympathy (Paldanius and Maatta, 2011), reducing suffering (Brennan *et al.*, 2013), and caring relationships that emerge out of love, mutual trust, empathy and responsibility, compassion and sacrifice (Brennan *et al.*, 2013; Gustin and Wagner, 2012). These conceptions of caring view the patient as a passive recipient of care with the locus of paternalistic control remaining with the practitioner as the active care giver. Nevertheless, healthcare policies increasingly refer to partnership and self-management (Epstein *et al.*, 2010) and there is a growing focus on how to empower and engage patients (Wood, 2017). Indeed, this research illuminates how risk is managed by these practitioners and is based on a professional concern towards the patient and negotiated through a connection of shared understanding, respect and trust.

For the participants in this study, managing risk is an interpersonal experience between practitioner, founded on a negotiation of safety as its conscious intention. According to Ray, Turkel and Kornblatt (2012), caring takes a conscious form in which the caregiver's intentions and actions provide effective assistance to the care recipient in response to human need (Ronald *et al.*, 2016). Findings revealed that how the patient interprets risk is determined, to a large extent, by this relationship between patient and practitioner in terms of care, communication, understanding and trust.

According to Drahošov and Jarošov's (2016), a caring relationship is achieved through active communication, providing information, and reduction of anxiety which breaks down barriers and helps protect patients' autonomy, dignity and comfort. The participants collectively described an intention to maximise safety through tailoring communication to the capacity of patients. In line with current

healthcare policy, the participants sought to empower patients to share in decision-making regarding risk and safety (Wood, 2017) but the challenges to this in the reality of practice were evident. Catherine described an interaction with a patient in which she "felt bullied…. loss of control…" (CatRef2). Findings from Drahošov and Jarošov's (2016) analysis on the concept of caring within nursing and social work emphasised the importance of a mutual, confidence-based relationship between the care provider and care receiver within the meaning of caring. This relationship included satisfaction of patient expectations and the aim of the professional to respond to patient's needs (Latimer, Chaboyer and Gillespie, 2015; Ronald *et al.*, 2016). Thus, the findings from this study illuminate an association between managing risk and a concernful (or *care towards*) practitioner/patient relationship.

Other definitions of care refer to the enablement of a person to seek greater independence (Groessl *et al.*, 2013). Beth described the impact of "*making and breaking of rapport"* on how she coped with managing risk and patient safety with her patients (BetInt1/2). Beth revealed a less than authentic connection where she gave credence to the patients' "*weird and wonderful beliefs*". (BetInt1). This she did in order to get them "*on-side"* and she speculated that the "*cranking up of rapport*" may be considered manipulative. Indeed, it could be considered coercive rather than facilitating empowerment and autonomy. Getting patients "*onboard"* for "*shared"* decision-making was a feature throughout and certain tactics and "*tricks"* to achieve this were described (TedInt1). Rather than manipulative, Gustin and Wagner (2012) may apply this to their definition of caring in which the nurse has to take in to account the individual's experience, recognize the patient's emotional state, and to meet their identified needs. Evidence suggests that patient

complaints are often about communication rather than clinician competency (Ha and Longnecker, 2010). This may be an underlying motivational factor in achieving good interpersonal relations with patients.

Princeton (2015) differentiates between conscious care and care that refers to in which one cares without consciously deciding to. This view separates the objective mental act of caring and the objective representation of that intention (Edwards, 2001). If ontological care is rooted in the being of human (Edwards, 2001), then Heidegger (1962) may offer an alternative interpretation of care in reference to *caring-towards*. This may describe situations when the practitioner has an all-encompassing concern or *care-towards* an issue of risk and safety of a patient whereby they will adjust the patient relationship accordingly to meet the risk. Thus, risk is managed though a complex dynamic of a relationship between patient and practitioner, which involves a concern of care where risk is shared in varying degrees between practitioner and patient.

The caregiver's competence provides reasons for selected actions of caring and for these practitioners this was the essence of how they prioritised and managed risk. The meaning of caring is experienced within the nurse–patient relationship in which they construct, interpret, and define each other's actions (Han *et al.*, 2014). The participants described responding to patients' specific needs, giving support and reassurance when needed. Indeed, caring is reflected through specific activities and interactions with patients (Ronald *et al.*, 2016). Caring, defined in this context, is as perceiving the patient from the perspective of their existence (Ranheim, Karner Köhler and Berterö, 2012). Han *et al.'s* (2014) perhaps idealistic view of caring, refers to the nurse seeking harmony between the patient's

soul and body. Such definitions challenge advanced nursing practice due to its lack of evidence base. However, a holistic approach which views patients as human beings with physical and emotional, psychological and spiritual components (Ronald *et al,* 2016), aligned with how these ANPs manage the risk and patient safety.

Caring has been described as a moral imperative, which means concern about, consideration for, and desire for meeting patient need in which there is a strongly held principle compelling a person to act (Princeton, 2015).

Managing risk for these participants was through a through caring moral imperative intention such as the *"correct"* thing or the "*right"* thing (BetInt1) or doing "*good"* for their patients (CatInt1). Dave (DavInt2) refers to the "*Hippocratic Oath"* of doing no harm (DavInt2). The traditional, moral obligation of medicine is the Hippocratic Oath which, according to Gillon (1994) seeks to provide net, medical benefit to patients with minimal harm; that is beneficence with non-maleficence (Gillon 1994). Nurses do not take such an oath, traditionally they have closer alignment concepts of caring (Watson, 2018). ANPs have advanced into the traditional domain of medicine. Participants describe a blurring of boundaries which requires constant reframing (Woo, Lee and Tam, 2017; Niezen and Mathijssen, 2014). The vulnerability of being-in what may be interpreted as a no-man's land or new territories, between the two professions creates boundary tensions (Lindblad *et al.*, 2010) and undoubtedly impacts on how risk is experienced and furthermore towards the development of a potentially new or different professional identity. Thus, the moral imperative has perhaps shifted where caring is not justification enough for decisions regarding risk and safety. Meeting the needs has a pre-

requisite of perspective from which those needs are judged and assessed. In the context of this research, this may mean either the perspective of the practitioner, patient or the service.

6.3.1 Caring for Self

The notion of caring for self was expressed by the participants in terms of an acute awareness of the position of professional vulnerability they might feel when managing and coping with patient risk. Nurses must be aware of their emotions and feelings and use them as strength in providing care (Ranheim, Karner Köhler and Berterö, 2012). The professional who knows and cares about their own personal strengths and limitations, has greater capacity for caring for others (Ghebrehiwet, 2011). Sharing, caring, and thus risk, with others was a source of comfort for the participants in this study. The ICN Code of Ethics for Nurses (ICN, 2012) affirms that the nurse sustains a co-operative relationship with co-workers in nursing and other fields. WHO (1999) Health 21 declares that working in a team enables the professions to solve complex health problems that cannot be adequately dealt with by one professional alone.

Participants referred to being aware of less experienced clinical staff to see, respond and cope with risk. "*This guy had been sitting in the waiting room with chest pain for four hours!*" (PhiInt1). Studies have supported this, identifying that experts think differently to novice nurses (Lyneham, Parkinson and Denholm, 2008; Dixon-Woods *et al.*, 2004; Broughton, 1998; Mandin *et al.*, 1997; Cash, 1995; Polge, 1995; English, 1993; Benner and Tanner, 1987; Dreyfus and Dreyfus, 1986). The experienced participants within this study recognised their role and necessity in

supporting others in managing risk. William described the "*security"* in being "*beneath the wings"* of more experienced staff and the Emergency setting with its support and medical staff was also described as a safety blanket when dealing with risks (TedInt1, Davtint1, PhiInt2). The support described given to others is not only active but anticipatory: "*I like to a walk round in the waiting room*" (DavInt1) and referring to the coping assessing the coping abilities of colleagues "*I like to see the whites of their eyes*" (DavInt1); "*I can hear a colleague struggling behind the curtains*" (PhiInt1).

However, this responsibility of supporting others in managing risk was identified by participants to be burdensome. Dave described the "*isolation"* of being "*left alone"* due to a perceived seniority of being able to cope which caused feelings of "*loneliness"* and feeling "*disrespected"* (DavInt1). In their analysis of the moral habitability of the nursing work environment, Peter, Macfarlane and O'Brien-Pallas (2004) found evidence of oppressive environments, moral suffering, and unclear, overwhelming role expectations. This can be related to this research; however, the findings of this study reach further than the emotional impact, particularly with regard to limited time, and dependency on their perceived level of support for themselves leads to an acceptance of an underlying fear. This finding has important implications for the support that all nurses, and particularly ANPs, require in order to make safe, morally sound and ethically correct decisions with regard to their risk management of patients.

The NMC reported in a 2017 survey of more than four thousand five hundred nurses who had left the profession in the previous twelve months that one of the top reasons for leaving the profession (excluding retirement) was working

conditions, including issues such as staffing levels. For the first time in recent history, the numbers of nurses leaving the profession is outstripping the numbers joining (NMC, 2017). If this worrying trend continues it is important to understand and respond to increasing expectations and pressures that today's nurses are working within. Both interprofessional and extraprofessional role tensions were identified by participants as barriers to manging risk who referred to isolation arising from their advanced role being framed within traditional nursing identify. This indicates specific education and support needs for ANPs (Kerr, 2016; Anderson *et al.*, 1996).

The ANPs role has advanced in the backdrop high profile safety-failings and patient losing faith in healthcare (Alrubaiee and Alkaa'ida, 2011) combined with practitioners loss of trust in patients and their own protection from litigation and support from their professional bodies (Brennan *et al.*, 2013). This is compounded by the reality of managing risk and patient safety in the context of time pressures of patient flow targets (RCEM, 2015). This collectively impacts not only on expectation but also the capacity of care that can be given. The call for nurses to refocus on care following the Cummings (2012) and the Francis (2013) report, is clearly a challenge.

The findings of this study highlight that there are inconsistencies about the notion of care as a pre-requisite to risk. These inconsistencies were not just between participants but also within individual data sets through the time period of data collection. Arguably, the Heideggerian design of multiple data collection over time, from both interviews and written reflections, that revealed the anomaly with regard to caring and risk which may otherwise have remained concealed.

Indeed, in collecting and analysing the data iteratively through hermeneutic cycles of interpretation through time, a key concept of *temporality* revealed itself in the data.

Heidegger's perspective on care may assist with interpretation as he too defines care not in the traditional sense of affirmative empathetic feelings towards something or someone. He states that "Dasein's Being reveals itself as *care*" (Heidegger, 1962 p.27/183) and in order to understand it "we must distinguish it from the phenomena which might be proximally identified as care such as will, wish addiction and urge. Care cannot be derived from these, since they themselves are founded upon it" (Heidegger, 1962 p.27/183). For Heidegger, *Dasein*, one's very existence is experienced from a perspective of *care* and *concern* of Being-towards that which is *ready* or *present-at-hand* in the world. Within the limits of this study, care can be interpreted as the participants concern towards what is perceived to be presenting itself as the most pressing possibility of risk at any given time, thus their immediate focus. Risk is a perception that is founded on either a *care towards* the patient or towards oneself or another matter. Perceptions of risk are constantly changing according to its situated context.

Heidegger also links the phenomena of care and concern to the basic state of anxiety:

> …always absorbed in the world of concern. In this falling Being-alongside… fleeing in the face of uncanniness (which for the most part remains concealed with latent anxiety, since the publicness of the "they" suppresses everything unfamiliar), announces itself, whether it does explicitly or not, and whether it is understood or not…" (Heidegger, 1962 p.237/193)

Thus, for Heidegger, *care* is the basis upon the way participants *Dasein* exists in the world as a *concernful everydayness* of *Being towards or* attending towards something rather than a feeling of sympathy, love and harmony. The findings of this study, in the context of risk and patient safety, identify with this conception of care.

6.3.2 Intuiting Risk

Participants described their work environment of limited time and information, having to make snapshot judgements about risk and safety. Informational shortcuts or heuristics being used in such clinical situations is evidenced (Lyneham, Parkinson and Denholm, 2008). Based on a perspective of care, participants described their "*gut-feel", "intuition", "inner voice",* and *"instinct"* as a tool used when coping with risk and safety. It was described as subtly underlying their practice from the moment they saw the patient and then coming to the fore in times of perceived high-risk, uncertainty, complexity or stress.

Intuition and use of heuristics have been attributed to situations of clinical uncertainty (Greenhalgh, Howick and Maskrey, 2014; Greenhalgh, 2013; Halter *et al.*, 2010; Croskerry, 2003; Cioffi, 2001; Beresford, 1991). Several studies have evidenced how practitioners' value non-linear approaches to enhance patient safety (Pirret, Neville and La Grow, 2015; Bowen *et al.*, 2014; Rasmussen, 2012; Ritter, 2003; Burman *et al.*, 2002; Offredy, 2002).

Carper (1978) defines intuition as the ability of nurses to immediately perceive a situation and to respond independently to a linear reasoning process. This definition, whilst dated, relates to the descriptions of the *snapshot* or the *look*

and rapid visual perception that universally was highly valuable in intuiting risk for these participants. Despite the age of the literature, it is clear that perceptual awareness (Field, 1987), pattern recognition (Solso, 2001), situational awareness (Reed and Ground, 1997) and *gut-feeling* (Pyles and Stern, 1983), expert intuitive grasp (Benner 1984) remain relevant to these participants and are associated with how risk and patient safety is managed.

These ANPs did not refer to themselves as experts, their perceived competence differed according to context, time and previous experience of presenting situations. Payne's (2015) study found that intuitive expert nurses made fewer errors and advocated nurse education and training to foster the development of intuition. Interestingly, Stinson's (2017) recent critical care study found no differences in Benner's stages of clinical experience related to their decision-making. Based on the participants in this study, their intuitive instinct was a valuable tool that aided in their risk coping. It is evident that as Robert, Tilley and Petersen (2014) stated, more studies that explore the nature and use of intuition on every level and in every setting is needed. The findings of this study do go some way towards illuminating this little understood area of managing risk and safety for ANPs and also identifies a potential link between non-linear processes in supporting practice when faced with risk and patient safety.

Links have been made between intuition and risk in the literature (Bowen *et al.*, 2014; Perez and Liberman, 2011; Sajjanhar, 2011; Miller, 1995). Being a risk-taker was identified by Miller (1995) as a characteristic of intuitive nurses, which also included the willingness to act on intuition, skills, client connection, and an interest in the abstract. Sajjanhar (2011) examined the management of head injured

children and identified that less experienced clinicians rely on guidelines, admission criteria, clinical theory and second opinions to achieve "safe" decisions. This concluded that guidance combined with clinical expert intuition is invaluable. Indeed, Bowen *et al.* (2014) found that senior clinicians used a high level of intuition to effectively manage clinical risk. Guidelines, whilst reducing risk, can lead to unnecessary hospital transfers, over-investigations, over-admissions, and increased costs (Haycox, Bagust and Walley, 1999). Indeed, willingness and determination to pursue those feelings of uncertainty, awareness of risk or "*peaking of interest"* (BetInt1/2) was a key feature in how anticipated risk was managed. Stolper *et al.* (2011) describe an intuitive gut-feeling monitoring process that has an effective component in reducing risk. Perez and Liberman (2011) identify that intuition requires supportive networks for mentorship through risk-taking activities. According to Engebretsen *et al.* (2016), dealing with uncertainty in emergency care is unavoidable and rather regrettable if attended to in a systematic and self-conscious way and can be a productive component of clinical reasoning. This aligns with the participants experiences in this study.

For the participants, risk taking is inevitable in an environment where time is limited. Participants described the constant pressures in terms of a constant flow of patients*,* referring to a *"conveyer belt"* (DaviInt1/2, SteInt2) which can be interpreted as implying the sense of processing. This pressure of time required quick assessments and rapid holistic understanding or judgement about a situation for these participants which needed to be achieved in the context of a "*snapshot"* (CatInt2, DavInt1/2) on time in a "*revolving world"* (DavInt1). According to the participants, the ability to manage this became greater with experience (Benner,

1984). Phenomenological enquiry described the "intuitive grasp" of expert nurses identifying a movement from analytical thinking towards intuitive decision-making as expertise develops. In the context of this research, the term "grasp" seems to imply *temporality* of the *relentless* pressing on of time. This was described at times an "*internal warning bell"* of a need to "*stop*, *re-evaluate"* and make sure no potential risk had been "*missed"* (SteInt1/2).

This "*inner voice"* may be related to a moral imperative as a strongly held principle compelling the participants to act. This can be related to the *call of care* as described by Heidegger, in which *"*Dasein, in the very basis of its Being, is care" (Heidegger, 1962 p.332/286). For Heidegger this *call of care* relates to conscience: "Conscience gives us 'something' to understand; it discloses" (Heidegger, 1962 p.314/269). Thus, the conscience brings something to the fore of the mind that needs to be better understood. For the participants this "*call of care"* presented itself as "*worry", "concern", "fear", "has something been missed?".* As Heidegger explains the *call of conscience* "is done so by way of summoning it to its own most Being-guilty". Our understanding "unveils itself as our wanting to have a conscience" (Heidegger, 1962 p.314/270). In order to unveil a *concealed* truth, and thus fuller understanding and interpretation of this *call,* one needs to *care* and turn towards rather than flee that which is not understood*.*

Heidegger refers to a *voice* of conscience and states "the 'voice' is *taken* rather as a *giving* to understand", stating that it "lies in the momentum of a push – of an abrupt arousal. The call is from afar unto afar. It reaches him who wants to be brought back" (Heidegger, 1962 p.316/271). Thus, rather this voice illuminating understanding or concealing the truth or what is not understood, it is merely a

warning, or a pointing towards that which is *not yet* understood. Thus, rather than the *clearing* in the trees as an enlightening of understanding, it is a heed or a *calling* that points towards the darkness in the trees of that which is not yet known or understood.

The "*fear* of *missing something"* or making mistakes was heightened when the patient flow was perceived to outweigh capacity. Patient flow was a term coined to address the issue of over crowing in ED's (Peck *et al.*, 2012). Maintaining and identifying constraints to patient flow defined as the passage of patients through the care pathway is imperative to safe efficient and cost-effective care according to the Royal College of Emergency Medicine (RCEM, 2015). However, the impact on the participants managing risk within this pressure of time with limited resources was clear in the findings of this study for their descriptions of the conveyer belt and Phil referred to getting the scan done quickly so that *"...we could move the patient on…the risk was managed*" (PhiInt2). Crowding in ED's has consequences for patient safety, burn out and staff retention (RCEM, 2015). Arguably, policies such as reduction of waiting times put in place to resolve these issues, are creating the very same issues compromising patient safety, staff wellbeing, and ultimately staff retention.

In summary the findings of this study lead to a potential new understanding of care in terms of how participants experience managing risk and safety of patients. This includes an intuitive feeling-based care or concern-towards the patients, situation or oneself.

6.4 Emotional Instinct

The participants referred to experiences of managing risk and safety in which they were guided instinctively by their moods and emotions such as feelings of comfort, being happy, worried and fearful. Clinical decisions are often made in challenging contexts that require clinicians to manage their emotions (Lerner *et al.*, 2015). The findings from this study highlighted the benefit of channelling these emotions to enhance the ability to cope with risk on a personal level and ultimately led to safer care.

It was clear that for all participants, how risk was managed was dependant on their mood or feelings at any given time. This affected how, and in what way, risk was perceived and the perceived competence and confidence in dealing with the risk. Variable feelings of worry, concern and fear appeared to fuel the way in which the participants responded and dealt with situations of risk and safety. This may be in the form of a constant awareness or alertness to potential risks: "*I like to know what is going on in the waiting room*" (AbiInt2). Thus, a low-level fear of potential risk as being "*not happy"* or "*worried"* about a patient or situation when something is "*peaking an interest*" of concern (BetInt1). The participants also described a mid-level fear of actual risk, or of one or potential multiple risks: "*I was worried for this guy*" (PhiInt2) when it was identified a patient had cardiac chest pain. Alternatively, it can present as an acute sense of immediate fear for potential or actual risk "*things come crashing down and the wheels fall off and you've got to act"* (DavInt1).

Emotion and affective states have been found to have arousing or motivational properties in decision making (Lerner *et al.*, 2015). It is recognised

that emotions, can enhance attention, cause conflict and compromise cognitive processing (Garfinkel *et al.*, 2016). Furthermore, emotions have been found to influence risky decisions in the area of finances (Kusev *et al.*, 2017). Nevertheless, decisions based on emotion can lead to bias and overriding of rational processes (Keltner and Lerner, 2010); indeed this was described by participants.

A review of the nursing literature linked emotional intelligence (EI) to clinical decision making (Bulmer Smith, Profetto-McGrath and Cummings, 2009). Some authors imply that without EI decisions are mechanical and inferior (Kooker, Shoultz and Codier, 2007). Whilst acknowledging that evidence suggests that emotion plays an integral role in patient safety, Heyhoe *et al.* (2016, p.11) asks "Are we brave enough to scratch beneath the surface?" inferring that there is a reluctance or fear to research and thus expose this emotive level of practice. The findings of this research identify that this emotive component of practice needs to be better understood with further research, and incorporated into training, education and support.

This underlying fear can be attributed to the inherent uncertainty and risk that ANPs working in acute settings cope with on a daily basis (NMC, 2014; RCN, 2008). In these settings informational shortcuts or heuristics are used to fill the gaps of limited knowledge and conflicting facts (Lyneham, Parkinson and Denholm, 2008). Within this time-pressured environment, the participants describe taking a "*snapshot"* to rapidly formulate a picture of understanding of patient presentations or situations. Similarly, Welsh and Lyons (2001) study, of psychiatric risk assessments, identified that when the evidence is complex, unclear, or uncertain, practitioners use tacit knowledge within their clinical judgment. Whilst the

literature recognises nurses dealing with uncertainty with which the use of tacit knowledge is associated, the emotional component and more specifically impact of fear on how risk is managed is not addressed directly.

The notion of angst and fear relates to the concept of care. Indeed, in order to fear something, you first have to care about it (Critchley, 2009). Heidegger (1962) offers a lens through which to understand the basis of the participants fear. *Dasein*, *already in the world*, experiences this world through a basic structure of care. Thus the participants are *thrown* in the world and are *falling* and thus, are absorbed in the world of coping with risk. *Circumspection* (Heidegger, 1962) or *concern-towards* is driven by the participants fear of missing something or fear of not *bringing close* and revealing that which *may* be concealed (Heidegger, 1962) – a potential unknown risk. Risk always lies on the potential *possibilities* of unknown future.

Heidegger (1962) refers to *revealing* and *concealing.* For the participants, the revealing of one risk may conceal another potential risk. Thus, in focusing on one patient who is presenting with an acute risk that requires action, one may not be aware of other potential risks in the waiting room, they remain *concealed.* Equally, mitigating one risk may create another, such as in x-raying a patient to meet the patient's expectations and to mitigate a professional risk of a complaint or a missed fracture the patient is exposed to, increases the unintended risks of exposure to radiation (Sajjanhar, 2011). Furthermore, rather than eliminating risk, this type of action simply changes its' form or perhaps moves the risk from one individual to another, such as between healthcare professionals (Ghosh *et al.*, 2012). This may happen in cases when patients are referred on to another healthcare professional,

or in cases when the patient with informed consent chooses to take the risk. Indeed, risk is complex and management of it is often laden with uncertainly and complexity (RCN, 2008; Albarran, 2006). It is under these conditions of uncertainty that feelings of fear arise.

An awareness of risk was triggered by "*worry"* about something not being right or potentially wrong. "*worry"* can be defined as "chain of thoughts and images, negatively affect-laden and relatively uncontrollable" (Borkovec *et al.*, 1983). It is a phenomenon experienced by most people (Davey *et al.*, 1992) described as occurring on a continuum ranging from occasional to frequent, fleeting to intense, and uncomplicated to challenging (Davey, Tallis and Capuzzo, 1996; Molina and Borkovec, 1994; Tallis, Eysenck and Mathews, 1992; Meyer *et al.*, 1990). According to Borkovec and Ruscio (2001), there is an implicit assumption in the literature that two forms of worry exist: *normal worry* (understandable, reasonable, relatively unproblematic) and *pathological worry* (persistent, catastrophic, highly distressing). This fails to interpret worry as a phenomenon that exists on a continuum (Ruscio and Borkovec, 2004; Borkovec and Ruscio, 2001) which was how the participants experienced this phenomenon.

The findings of this study depict participants moving across the spectrum from an over-confident, "*maverick"* risk-taker at one end, towards the middle of the spectrum, of being "*happy"*, "*feeling confident"* and "*competent"*, and "*safe"*. Finally, towards the other end of the spectrum there is "*vague niggle"*, "*suspicion",* "*concern",* which can move to *"worry", "fear"* and *"dread*". Movement towards the latter end of the spectrum can be a sudden alarm or *"warning bell"* following acute alertness to a potential risk previously concealed. This relates to Heidegger's

explanation of “Even in the most indifferent and inoffensive everydayness of the Being of Dasein can burst forward naked; that it is and has to be” (Heidegger, 1962 p.173/134).

Beth describes working with this continuum through her analogy of the “*goal posts”*, one – red - risk adverse and the other overly risky as well as how she “*aims for the middle”* and how sometimes a “*wobbly football* can *ricochet off the post”*. She also describes this continuum as a “*sliding scale”* that requires “*titration”* (BetInt1/2). Additionally, the findings demonstrate how fear on the lesser end of the scale of concern can be seen as a necessary therapeutic level that facilitates an alertness or awareness and responsiveness to risk that positively drives safe practice. These findings also identify how this same positive force can become a negative pathological hinderance to managing risk safely. This demonstrates a need for educators, policy makers, healthcare leaders, and ANPs themselves to take in to account and factor in this area when preparing and coping with risk and protecting both patient and practitioner safety.

Worry or *concern-towards* some participants lead to avoidance. An example of which following a bad experience: “*I always avoid going there now*” (DiInt2). This applied to the cognitive avoidance theory of worry where one is not actually fully engaged with the perceived threat that acts as the trigger for worry. They cognitively “*dance”* around the imagined threat, thereby not exposing themselves to the full imagery or depth of processing that would be involved in normal thinking about a threatening trigger (Molina and Borkovec, 1994; Ruscio and Borkovec, 2004; Borkovec and Roemer, 1995). Rather than “*dancing around”,* Di is describing

actively avoiding. Heidegger's (1962) refers to a basic state of anxiety and *fleeing in the face of uncanniness*:

> For the most part its mood is such that its thrownness gets closed off. In the face of its thrownness Dasein flees the relief which comes with the supposed freedom of the they-self. This fleeing has been described as a fleeing in the face of uncanniness which is basically determinative for individualized Being-in-the-world. Uncanniness reveals itself in the basis state of anxiety (Heidegger, 1962, p.321/276).

Manifestations of worry, such as avoidance, have implications for stilted development and learning, and may ultimately cause exposure to further risk if unfamiliar, uncertain and concerning issues are not addressed by practitioners.

The ability to tolerate risk is closely related to moods and emotions such as fear and worry. Koerner and Dugas (2006) describe the Intolerance of Uncertainty Theory where worry is motivated and maintained by an individual's dispositional intolerance of uncertainty. This stems from beliefs about uncertainty being unpleasant and stressful, and involving heightened emotional, cognitive and behavioural vigilance towards the identification of potential threats. Conversely, when able to tolerate uncertainty, decisions were able to be made whereby the patient has greater autonomy and self-determination. Examples from these findings is facilitating a patient to have an alternative treatment to a plaster of paris, even though it is considered the best form of treatment for a specific fracture, because it was his informed choice (DiRef2); sending a patient with a fractured hip to hospital in a taxi rather than waiting for a delayed ambulance (BetInt1); or, indeed, sending patients home on a "*wait and see basis",* trusting that safety-netting advice is understood and will be adhered to (CatInt2, KinInt1/2,

TedInt1). Bardes (2012) argues that working outside of guidelines can facilitate a more patient-centred approach. Indeed, it appears from the findings of this study that the level at which practitioners are able to tolerate risk and uncertainty correlates with them being able to shift to a more patient-centred approach.

The Metacognitive Model understands the development and maintenance of worry within a framework of self-regulation to regulate cognitive behaviour (Lusignan, Singleton and Wells, 2004). Positive metacognitive worries are those that warn or motivate. These can be the "*alarm bell"* or "*trigger"* described by many of the participants, or the fuel to fire one into action to respond "*quickly"* to potential critical need (PhiInt1). Negative metacognitive worries are those where worry escalates and can become uncontrollable or even dangerous such as being "*paralysed by fear"* (DiInt1) with an experience of managing risk that can be "*harrowing*" (DavInt2).

The Mood-as-input Hypothesis proposes mapping the mechanisms of worry episodes, in order to explain its potentially perseverative nature; thus, worrying is essentially a problem-solving process that is stuck in a loop (Davey *et al.*, 2005, 2003; Startup and Davey, 2001). The "stop rule" is where an individual uses their mood as a guide to whether they have identified a satisfactory outcome, with a negative mood indicating that this has not occurred (Davey *et al.*, 2003; Startup and Davey, 2001). This was clear with the participants who described having unresolved feelings of worry or concern for a patient, which led them to seek some form of resolution to achieve a feeling of being "*happy"* that the patient was safe.

The Contrast Avoidance Model of Worry suggests that individuals who worry to a significant level are by nature more sensitive to contrasts in emotion. They

engage in excessive worry in order to generate significant levels of negative affect and, in turn, avoid the *"shock"* of a future negative event (whether it actually occurs or not) (Llera and Newman, 2014; Newman and Llera, 2011). For the participants, excessive worry or fear can lead to sleepless nights, avoidance, defensive practice in which rules are *followed blindly* (BetInt2) and not applied according to individual patient's situations. According to the participants, this can potentially lead to more harm. A greater understanding and support for ANPs in managing and coping with these feelings of concern and worry is imperative to enable risk to be managed effectively and safely.

Svensson and Fridlund (2008) carried out a study of twenty-five Swedish ambulance nurses with regard to *worry* in their professional life. Semi-structured interviews identified factors influencing the extent of worry such as experience knowledge and support from others. Other studies on worry have demonstrated how lack of control can be a strong precipitating factor of worry. Hinton and Earnest (2010) provided evidence of Mood-as-input Hypothesis (Turner and Wilson, 2010), with mood precipitated by prior aversive or threatening experience (Muris *et al.*, 1998); personality factors (Roth and Eng, 2002); and provided insight into negative effects on health and worrying (Hinton and Earnest, 2010; Boutain, 2001).

Proponents of positive psychology advocate that it is the absence of distress, combined with the presence of positive functioning, that is reflective of good mental health and well-being (Seligman and Csikszentmihalyi, 2014). Indeed, the Health and Safety Executive Statistics (HSE) define work-related stress "as a harmful reaction people have to undue pressures and demands placed on them at work" (HSE *et al.*, 2013) and refer to the significance of the number of working days

that were lost due to work-related stress and the impact this has on individuals and healthcare provision as a whole.

From the findings of this study it was clear that for some, participants fear, worry and concerns were not necessarily considered a negative and for some were seen as a positive element in coping with risk and safety. "*You have to have a bit of fear*" (DavInt2), "*It keeps you alert*" (KinInt1). Based on these findings it appears that emotions could mediate how participants responded to coping and managing risk. From the wider literature, worry was found to help individuals cope with potential problems and, thus, was seen as a coping mechanism (Cartwright-Hatton and Wells, 1997). Worry and fear has been found to potentially enable individuals to be prepared (Svensson and Fridlund 2008) and detect and cope with a difficult future event in a more effective way (Muris *et al.*, 1998). Worry can enable analysis of situations (Davey, Tallis and Capuzzo, 1996) and aid and motivate problem-solving (Turner and Wilson, 2010; Svensson and Fridlund, 2008; Cartwright-Hatton and Wells, 1997) by acting as a stimulant, as well as clarifying thought and concentration (Davey, Tallis and Capuzzo, 1996). Thus, it would seem that the energy from the worry and concern that arises out of managing risk and safety has the potential to be positively channelled. Heidegger (1962) warns of this potential for interpretive understanding of situations that may remain in darkness if moods are not channelled positively:

> The pure 'that it is' shows itself, but the 'whence' and 'whither' remain in darkness. The fact that it is just as everyday a matter for Dasein not to 'give in' to such moods – in other words, not to follow up their *disclosure* and allow itself to be brought before that which is disclosed (Heidegger, 1962 p.173/135).

Here, Heidegger is describing an everyday normality of living and coping with moods and emotions, seeking to remain in control rather than be controlled by one's own moods.

The focus of this section has been on fear, worry and concern. It is recognised that these were not the only emotions that participants were guided by. Positive feelings of happiness, content, relief, and feelings of resolution were also important elements to managing risk. Whilst these feelings act as a guide, they can also hinder the management of risk and safety, guiding one away from what should critically be the focus. Indeed, emotion can moderate selective attention (Bellaera, Von Mühlenen and Watson, 2014). Several participants described having selective attention to specifics which, perhaps, led them down the wrong diagnostic "*path"* (WilInt1/2, KinInt1, SteInt1/2). Others described the exhilaration of being on the "*edge of risk"* (PhiInt2), *"walking that line"* (DavInt1), "*feeling your edges"* (AbiInt1), and the motivation to act quickly to "*zip around"* with the "*zing"* that anxiety or anger can give you (PhilInt1). Thus, it is important to investigate the extent to which emotions, such as fear, influence spatial and temporal attention in specific contexts (Bellaera, Von Mühlenen and Watson, 2014). The specific context for this research being the environment in which ANPs manage the risk and safety of their patients.

Karlou (2011) carried out a phenomenological exploration of fear in everyday life through semi-structured interviews with six individuals. Findings were that fear is a natural phenomenon that is avoided due to its aversive nature. This also relates the "*fleeing"* from the unknown (Heidegger, 1962) and cognitive avoidance.

According to Karlou (2011), fear brings a sense of lack of control and uncertainty and it effects behavioural, mental, emotional and physical levels. It also has a close connection to change, choice, regret, death and loss. For the participants in this study, whilst reflecting in action is clearly beneficial, when in a state of fear, it can be challenging. "*When the shit hits the wall… gut-instinct is all I have*" (DavInt1). Karlou (2011), in his analysis on the concept of fear, acknowledges the challenge of reflection at critical times and states that reflecting on fear happens after the event. Heidegger (1962 p.325/280) states: "All experiences and interpretations of the conscience are at one in that they make the 'voice' of conscience speak somehow of 'guilt'". For the participants, fear and guilt were feelings expressed as: "*I failed her"* (CatInt1*), "I let her down"* (KinInt1), *"Did I miss something?"* (WilInt2). Heidegger (Heidegger, 1962 p.328-329/283) relates *guilt* to *ought,* which is defined as a lack – when something which ought to be may be missing. To be missing, however, means not *Being--present-at-hand.* Thus, the guilt is the sense for the practitioners that there is an absence of an ability to cope with the risk they are presented with because of their own capabilities. This is combined with the context of the risk they are being presented with. The implications of these findings are that the consequence of risk pressures in the work environment at times outweigh the ability to cope. Thus, the practitioners potentially suffer emotionally. Clearly without recognising and managing this situation, ultimately patient safety will be further compromised.

For the participants, reflections on incidents of managing risk can happen after the event during the drive home or, indeed, cause sleepless nights. This guilt is also connected to the description of conscience. According to Heidegger (1962

p.326/281) “a ‘good conscience’ is a conscience of ‘no guilt’”. This conscience of *no guilt* can relate to the participants descriptions of feeling of being “*happy”* or “*comfortable”* with knowledge, understanding and responses to a situation. This feeling of happiness may have replaced a feeling of worry or concern, and a risk coping behaviour, such as safety-netting, may have shifted this mood into the comfort zone away from fear. Heidegger (1962 p.175/136) states that “When we master a mood, we do so by way of a counter mood; we are never free of moods”. Heidegger (1962 p.327/282) referred to “Being-guilty” as also having the significance of “being responsible for”. For the participants, feelings of guilt are tied into how they understand their purpose, their role, their existence. If they see their purpose as to keep patients safe “*that’s what we do, innit? We keep patients safe*” (DavInt1), then to fail to enhance patient safety and “*not make a difference”* (BetInt2, CatInt1) may lead to feelings of guilt.

For these participants, feelings of guilt are a subconscious checking tool to intuitively assess whether risk and safety has been achieved sufficiently according to their own *moral imperative* of care. The participants place value on this and thus the findings of this study are that recognition and understanding of such feelings has a place within interpreting the management of risk in practice and should be recognised in the preparation and on-going support of ANPs in practice.

Wilkinson (2001) wrote of the links between uncertainty, anxiety and risk, and questions whether there is more anxiety because people are more risk conscious in what he described as a risk *society* (Giddens, 1998; Beck, 1992). Connections have also been made with these concepts to trust (Lingis, 2004) and social *trust* (Earle and Cvetkovich, 1995). Bauman (2006) refers to people living in a

constant state of anxiety as an everyday social condition as a *time of fears.* There is a multi-system, physical response to fear (Jackson and Everts, 2010). Emotions, such as fear, can be transmitted between individuals socially (Brennan, 2004). Social anxieties are converging with discourses of risk, which has a strong moral dimension, which he refers to as the "moralization of risk" (Hier, 2002). Reflexivity of my own fears with regards to risk is shown in Figure twenty.

August 2016 Fear of risk.

What are my views about risk? Reflexivity should consider my personal values. As an ANP, a human-being, it is concern for patient safety that drew me here in the first place… such an intentional concern-towards impacts at every research stage. I care. Risk concerns me. I need to maintain this reflexive awareness. I need to be aware.

Figure 20: Reflexivity Box 6

6.5 The Ethics of Risk

Practitioners who work in urgent and emergency care settings have limited time (Hughes, 2004) and make quick clinical decisions to treat patients urgently (Ozcan *et al.*, 2014). Common ethical issues are more complicated in these settings (Gisondi *et al.*, 2004), particularly when dealing with risk and patient safety. Indeed, in the context of healthcare ethics, Gillon (1994) points out that whenever we try to help others, we inevitably risk harming them (Graham, 2011; Pollard, 1993) .

This study revealed the lived experience of managing risk and patient safety is embedded in the basic principle of doing good and avoiding potential harm. The participants emphasised that when coping with risk, they just wanted to *"do good"* for their patients. The very essence of their purpose or existence as a practitioner "*to keep the patient safe*" (PhiInt1, CatInt1/2). This relates to Beauchamp and Childress' (2013) biomedical ethical principles of non-maleficence, beneficence and autonomy (Nys, Denier and Vandevelde, 2007). Autonomy is defined as deliberative self-rule. Non-maleficence and beneficence are defined as to do no harm and to do good respectively (Gillon, 1994).

Participants describe cranking up rapport (BetInt1) or "getting patients onboard" (TedInt1) inferring approaches that favour paternalism over promotion of autonomy. Paternalism is the intentional overriding of a person's known preferences of actions by another person, where the person who overrides justifies the action by the goal of benefitting or avoiding harm (Beauchamp and Childress, 2013). The focus on autonomy in recent years has led to paternalistic medicine becoming increasingly unpopular as it entails clinicians telling patients what is good for them without necessarily having regard to their needs and interests (Sainton, 2018). Suspicions regarding the "doctor knows best" attitude are evident (Nys, Denier and Vandevelde, 2007). Paternalism, characterised as the antithesis of autonomy, is widely thought not to have any role in medicine (Pollard, 1993). Paternalism is often expressed in terms of a conflict between the principles of autonomy and beneficence (Sainton, 2018).

The general public has been increasingly confronted with scandals revealing that choices made through a paternalistic model have had serious detrimental

consequences for the well-being of patients (O'Neill, 2003). Kultgen (1992) made a case for paternalism in which it might be justified within consent which may be justifiable if it is possible to achieve paternalism that does not restrict (Cohen, 1986). Participants described an interaction with their patients in which they used "*tactics"* or manipulative communication to communicate to the patient to help them to understand the probabilities of potential risk. This was particularly helpful when they perceived the patient, in that moment in time, as not having the capacity to comprehend. Rather than paternalistic behaviour, the findings of this study suggest the participants professional practice sought to achieve patient safety. Nys, Denier and Vandevelde (2007) believe that to achieve good care in those cases where capacity may be an issue, one needs to transcend the dichotomy between autonomy and paternalism. Historical tensions between autonomy and paternalism is well documented (Tau''ber, 2001; Kultgen, 1992; Archard, 1990; Dworkin, 1988; Cohen, 1986). Some argue that the common understanding of autonomy is born out of a historical context of anti- paternalism (Nys, Denier and Vandevelde, 2007). There is an assumption that autonomy refers to freedom and independence while paternalism involves coercion and restriction (May, 2018; Tauber, 2001; Kultgen, 1992; Archard, 1990; Dworkin, 1988; Cohen, 1986).

Beauchamp and Childress (2013) argue that instances of paternalism can sometimes be fully justified, and beneficence and non-maleficence should override concern for patient autonomy, although respect for autonomy is important in that it should not outweigh other moral considerations. Enhancing a person's well-being happens by listening to them and allowing them to make their own decisions; they should be allowed a space in which they can determine and pursue their own

conception of the good for true self-determination (Nys, Denier and Vandevelde, 2007) or indeed "*what is best"*. Dave referred to patients as a "*commodity*" as "a way to get to the end of the day" (DavInt1). This raises issue with the principle that people should not be treated as a means to an end (Pullman, 1999). Nys, Denier and Vandevelde (2007) wrote that humans possess inviolability because they have the capacity to set ends for themselves. Respect for autonomy is often framed in terms of desires or choices, thus informed consent is considered vital tool against paternalism (Nys, Denier and Vandevelde, 2007). Informed consent however has limitations (O'Neill, 2003) in that it can put the burden of responsibility on patients when they may rather rely on the judgement of experts (Loewy, 2005).

Participants in this study described various ways of empowering their patients to make decisions and varied methods for making judgements about their patients' capacity to understand or want the autonomy. There was at times a conflict of wanting to protect the patient by perhaps "*drip feeding information"* in a deliberate way in order to achieve the safest outcome. Ozcan *et al.* (2014) state that the main requirement for informed consent is the obligation to tell the truth. Thus, the avoidance of truth-telling is encouraged by the paternalistic behaviours of practitioners (Guven, 2010). Indeed, within a liberal *s*ociety there is an assumption that persons are autonomous and comfortable in making decisions for themselves (Kittay, 1999). Considerations also need to be made regarding the transforming effects of illness, which may radically alter a person's decision-making capacity; these cannot be ignored (Pollard, 1993). Practitioners in this study suggested that patients did not always want to participate in decisions about their care; thus, the implicit assumption that patients were to make autonomous decisions about their

treatment appear to be dependent on the patient and individual situations. Furthermore, an equally key factor was the extent to which practitioners, themselves, were comfortable, competent or experienced enough to cope with sharing varying degrees of risk with their patients.

This association of a caring moral imperative can be related to beneficence in which the practitioners feel they ought to be doing what is best for the patient. However according to Farber Post and Blustein (2015) "todays advancing healthcare forces the dilemma of when *can* becomes *ought"*. This refers to the gap between theory and the reality and complexity of practice. ANPs are challenged with balancing the values, interests, benefits, and burdens that arise from aiming to achieve informed, principled clinical decisions about how, when and whether interventions should occur. Examples within this data was ANPs enabling less safe hospital transfers against guidelines or facilitating patient choice when it was not the best treatment for a condition when the patient chose to take the risk.

Principles of liberty assert that the only purpose for which power can be rightfully exercised over any member of a civilized community against his will is to prevent harm to others (Sainton, 2018). An understanding and interpretation of the concepts of autonomy and paternalism is temporal and, thus, can only be understood in the context of not only perspective but also time. Thus, a current universally accepted meaning is challenging as their significance varies widely. Festenstein (2018) argues against the concept of liberty on the basis of questioning how the freedom to make rational choices can be achieved in a context where there is no rational best to decide between them. It is important that ethical concepts, such as autonomy and paternalism, must be examined in their applied

contexts (Pollard, 1993). Thus, although evidence-based guidelines are the ideal safe approach, they are not always adhered to when judgements are made which are situated in a context of multiple patients.

For the participants in this study, their management of risk and patient safety is fundamentally aimed at safeguarding patients from harm. The obligation to provide nett benefit to patients also requires practitioners to be clear about risk and probability when making assessments about harm and benefit (Gillon 1994). Thus, risk management and non-maleficence are closely related. Risk is a complex phenomenon for both patient and practitioner. It is important to consider that what constitutes a benefit for one patient may harm another Gillon (1994). With regard to autonomy, within the findings, there was reference to a sense of angst that the independent and autonomous nature of being an ANP: "*the buck stops with me*" (DavInt1), and the responsibility of being "*the last practitioner to see the patient*" (AbiInt2), particularly with regard to the perceived risk of discharging patients home rather than referring them on for ongoing care or assessment.

Autonomy is a self-reflective capacity, which permits an individual to be self-determining, and to take responsibility for making choices as an expression of who one is and what one authentically desires (Pollard, 1993). From the findings of this study, it is questionable as to whether ANPs are always making such decisions alone. Participants described making decisions alongside other colleagues, seniors, juniors, medics, and the patients and their families and, thus, are rarely, if ever, making decisions independently. Often decision-making is shared and conferred with other practitioners who offer support and guidance. Furthermore, one may question how ANPs can be self-determining with decision-making about their

patients when the patients themselves are so clearly often involved in the treatment/care options. The value of a patient's right to self-determination and the practice of informed consent are considered supremely important in present-day healthcare ethics (Nys, Denier and Vandevelde, 2007). This research highlights the need to understand the issues of autonomy of both the patient and the practitioner and, furthermore, how these two autonomies interact, and this understanding will inform education and support programmes for future practitioners.

Participants within this study describe promoting autonomy in their patients, such as through equipping the patient to make an informed decision, however this decision was shared between practitioner and patient. Kittay (1999) contends that individual decisions are never truly made in isolation, which is true of practitioners and patients alike. One may question whether a patient can be truly autonomous and self-determining within a healthcare system with variable capacity to make fully informed decisions about their risk and safety. Kittay (1999) refers to a notion of *relational autonomy,* in which obstacles are considered in terms of the self being viewed as situated in a matrix of relationships with dependencies and interdependencies (Donchin, 2001). If, as Heidegger (1962) asserted, one exists (as *Dasein*), *already in the world* with *others* and lives a life *in-authentically* according to the *rules* or expectations of *others* rather than living *authentically* as a self-governing *Being*, then surely an acceptance of this *relational* must be taken into consideration when applying a phenomenon such as risk to the concept of autonomy in healthcare.

Furthermore, in the context of today's healthcare with blurring of role boundaries, relational autonomy raises important questions regarding delegation

and accountability. Indeed "passing the buck", referring patients and other safety-netting practices described by participants may fall under delegation. Delegation is defined as the transfer to a competent individual, of the authority to perform a specific task in a specified situation (RCN, 2012). ANPs, as with all healthcare professionals, are accountable for delegation, whether actioning or as a recipient. The NMC (2016) refers to *Safe Delegation* and advises that any delegation must not cause harm, must be comprehensive, competent and potential risks must be identified. Indeed, this refers to the professional duty of care and legal liability to patients that all delegation should be in the patient's best interests. The GMC publication Good Medical Practice offers guidance for doctors according to the Medical act on role delegation (GMC, 2014). In accordance with the Medical act, all patients in secondary care are admitted under a consultant from the medical profession who assumes ultimate responsibility for that patients care (GMC, 2013). For doctors to delegate responsibility, care or parts of their role to another non-medical practitioner, they must be satisfied that this person has the appropriate knowledge, skills and experience. This opens questions of where authority and accountability blur and thus, in this context, it is indeed questionable whether ANPs or other professionals have true autonomy in practice.

It would seem that in managing decisions about risk and safety neither practitioner nor patient can be purely autonomous. It is argued by some that the concept of autonomy is ill-suited to healthcare, as autonomy may disregard the dependant nature of patients on healthcare professionals (Nys, Denier and Vandevelde, 2007). The ANPs referred to tier autonomy positively, in terms the freedom to make decisions independently, but also referred to the weight of

responsibility. This dichotomy suggests, perhaps, that autonomy has moved further from its original moral context to the extent that it signifies no more than a person's expressed intention, according to (Pollard, 1993). Christman and Anderson (2005) referred to the shift from Kant's moral autonomy to personal autonomy. Indeed, the concept of autonomy continues to shift with the changing context of time. It is interesting to note that in their definitions of ANPs, the International Council of Nurses (ICN, 2018) and the Career Framework for Health (CFH, 2010) and the Health Education England (HEE, 2016) do not use the term autonomous, yet the National Midwifery Council (NMC, 2014) does and the multi-professional framework for the Advanced Clinical Practitioner refers to a level of practice characterised by a *high level of autonomy*. The findings from this research are evidence that for those practitioners, managing risk and patient safety, rather than an autonomous activity, is a compromise or negotiation of a shared understanding with the patients within the context of situation in terms of place and moment in time.

Ozcan *et al.* (2014) study of 739 Emergency Care Practitioners in Turkey, used anonymous questionnaires to assess ethical issues and reasoning. Findings were that truth-telling was found to be the most common ethical issue and it was speculated that this may have been impacted by the limited time patients had in the emergency setting. Further findings were that despite the fact that the Emergency Care Practitioners did not have any formal ethical training they felt confident with their competency to deal appropriately with ethical dilemmas in practice. Ozcan *et al.* (2014) point out that most ECPs resorted to "irrational methods such as conscience, intuition, or observation" to address ethical issues

and, furthermore, declared that this "irrationality" was "perpetuated" because they primarily asked their superiors for advice (Ozcan *et al.*, 2014). Recommendations from this study were that ethics training programs that meet the specific requirements of emergency services are required and ethical guides should be prepared that are accessible and practical for emergency care. The findings from this research indicate that ANPs would benefit from education and training in dealing with ethical issues on a practical level. However, the assertion that methods of conscience, intuition and observation as being irrational, needs further exploration in order to be justified. In experiences of managing risk, practitioners highly valued support from and sharing risk with others. This can be related to relational *autonomy*. Furthermore, the ANPs in this study certainly identified reliance of conscience, intuition, and observation as important tools in assisting in situations where there is limited time and information. It is the contention of this research, therefore, that rather than declaring these as irrational they need to be recognised, illuminated, and understood. The data of this study has begun illuminating this area. However, more research is needed to achieve the necessary comprehensive interpretation of this region of practice.

For the participants in this research, in making decisions about risk and safety taking in to account, or caring about, the patient context was of importance: "*I was very aware Christmas was coming up*" (KinInt2), "*he was a long-distance lorry driver, that was his livelihood*" (PhiInt1), "*he did not want to go to hospital*" (DiInt2). Participants in a short space of time gained a sense for who the patient was. O'Neill) (2003) coined the term actual autonomy, which refers to a tacit, beneath the surface dimension of autonomy, recognising that people are socially

embedded with their own specific personality, which should be respected. According to Nys, Denier and Vandevelde (2007), respect for actual autonomy means that care takers should be sensitive to what the recipient deems meaningful in their life, and it should be dialogical and tailored to the specifics of the individual. Following the outcomes of this research, it would be argued that healthcare givers themselves are also socially embedded with their specific personalities and it is the alignment of these two dimensions that requires more attention and recognition. Focussing on and for these participants and caring about the actual autonomy of day-to-day activities as being important to the individual were often factors of complexity that arose when making decisions about risk.

Practitioner efforts to be both medical expert and carer can be hindered by healthcare organisations (Kittay, 1999). Nys, Denier and Vandevelde (2007) concluded that care, from an ethical perspective, should not be conflated with paternalism because good care is the product of a dialogue. Kittay (1999) asserts that rather than being paternalistic, care givers should *intuit* through discussions and careful attentiveness to discover what form of care patients require.

Participants discussed making decisions based on what was best for patients based on a principle of care. This may involve "*manipulating rapport"* (BetInt1/2) or using certain "*tricks"* such as" using *the wife to persuade*" (TedInt1) in order to get patients "*onboard"* with his judgement about what was the safest plan of care. Such *inauthenticity* described by Heidegger (1962), is a normal *everyday* state of *Dasein* (existence). However, in the context of professional ethical codes of practice it might be questionable. Nevertheless, rather than doing what is expected by *Others*, it is a deliberate conscious discourse to achieve a means to

end which in these instances is to make the patient safe from a position of care. This raises questions as to whether this is professionally, ethically or morally sound and rather than respecting the patient is based on a consequentialist approach in which consequences are considered to be an important indication of the moral value of ones actions (Butts and Rich, 2013).

For participants, achieving an equilibrium between autonomy and beneficence was perhaps an unrealistic goal and conflict ridden. Indeed, paternalism and autonomy, rather than being at opposite ends of a spectrum, were interwoven from a position of care through a didactic interaction with patients within the complexities of today's practice. Recognising and illuminating the ethical and moral uncertainty and complexity involved within the practice of ANPs managing risk and safety is imperative in supporting these practitioners within their practice to achieve the most benefit and least harm to patients. According to the findings of this study, the degree to which this can be achieved, is according to context, perceived capacity, competence, experience, and knowledge base.

6.6 Comfort Zone of Knowledge

For participants managing risk and patient safety is facilitated through use of a vast knowledge base accrued over time. The findings revealed the how participants applied both theoretical and experiential know how to situations in which potential risk presented. How participants experienced this large knowledge base is explained well by Abigail: "*there's loads of stuff sitting in my head…with bits of information you gather with a back door dribbling out old information*" (AbiInt2). Knowledge *sitting* implies inactive, at-rest and comfortable thus this knowledge

provides a zone of comfort. Indeed, familiar presentations of risk were applied to this knowledge comfort zone with ease. Conversely, feelings of discomfort arose from unfamiliar or uncertain situations. In such situation's participants responded to situations with fluidity of a knowledge base and expertise.

Theories of nursing knowledge are well documented in the literature (Christensen and Hewitt-Taylor, 2006; Rolfe, Freshwater and Jasper, 2001; Schon, 1984) as previously discussed. However, how ANP knowledge is applied when managing risk and safety is less well documented. Rolfe, Freshwater and Jasper (2001) constructed a typology of nursing knowledge as scientific knowledge, experiential knowledge, and personal knowledge, and each of those were split into knowing-that (theoretical knowledge) and knowing-how (practical knowledge). Knowing how relates to (Schon, 1984) description of knowing in action, which is steeped in the practical knowing of here and now (Rolfe, Freshwater and Jasper, 2001; Ryle and Golynkina, 2000). This present tense, Heidegger (1962) refers to as absorbed in the *everyday coping* with what is *ready-to-hand*. Where decisions are made "on the hoof" (BetInt2) with "eyes shut and hands tied behind your back" (BetInt1), "*It's automatic pilot*" (WilInt1). Indeed, this know-how (Rolfe, 1998) or knowing-in-action (Schon, 1984) is the ability to recognize patterns and to perform automatically without being aware of the knowledge or learning associated with that action (Christensen and Hewitt-Taylor, 2006).

Ryle and Golynkina (2000) described propositional knowledge of knowing-that which can be related to participants, stating affirmatively, "*I just knew*" (KinInt2) or "*I've got it! I know it now*" (AbiInt1). Interpretation of these concepts

link into literature about pattern recognition (Christensen and Hewitt-Taylor, 2006; Mattison and Christensen, 2006).

Pattern recognition and intuition were the hallmark of Benner's (1984) work on nursing expertise. Attributed to expertise is the ability to focus in on a diagnosis or understanding of a situation, seemingly without consideration of alternatives, through a less rule-bound, more fluid and flexible approach (Scholes, 2006; Benner, 1985). Benner's work has been criticized for giving simplistic reflections of know-how practical knowledge (Jameson, 2003) Stinson's (2017) study found there was no strong correlation between experience, expertise and clinical decision making in critical care nurses and no differences found in the Benner stages of experience in relation the overall decision-making process. Benner, Tanner and Chesla (1992) argued that for the intuitive expert practitioner, requisite knowledge is so deeply embedded in practice that it is difficult to verbalise. Expertise operates at the top level of Miller's (1990) clinical competence pyramid in which things are done without knowing how or unconscious competence. However, Cruess, Cruess and Steinert (2016) challenges the appropriateness of this be the top level of competence for an aspiring practitioner. Indeed, the notion of expertise may be less relevant for advancing practitioners who are constantly pushing their boundaries into new areas. In today's healthcare, transparency and accountability are imperatives and this area of decision-making around risk needs to be better understood (Trinder, 2008). Indeed, it is for these reasons where over-reliance on *expertise* can cause bias and lead to error (Henriquez and Korpi-Steiner, 2016). It is against this background of metacognition, defined as *thinking about thinking* (Hayes, Chatterjee and Schwartzstein, 2017), that evidence-based guidelines have been developed.

Schon (1984) believes reflection in action occurs as practice is taking place and reflection on action is reflecting on a recent incident or experience. Reflection-in-action has a critical function in questioning the presumptuous function of knowing-in-action: "*never assume anything*" (PhiInt1). Pitfalls include "*confirmation bias"* or getting "*stuck in a pigeon hole"* (SteInt1) or being "*railroaded"* (KinInt1) or "*put on the wrong track"* (WilInt1) by another practitioner's working diagnosis. Many of the participants referred to "*stop", "rethink" and "reassess"* (SteInt1/2). This can be related to Kahneman's (2012) book 'Thinking Fast and Slow', where he describes two ways of thinking. System I thinking is fast, automatic, frequent, emotional, stereotypical, and unconscious and System II thinking is slow, effortful, infrequent, logical, calculating, and conscious. Arguably, system I facilitated the instant impression or judgement made by "*eye balling", "looking", "seeing"* the patient and System II involves being the detective or investigator, seeking and assimilating objective information to gain a fuller, more holistic picture or understanding of a situation in order to manage risk as effectively as possible. Within the context of this research this system I *look* whilst subconscious, appears to have an important purpose.

In looking through a Heideggerian lens, the basic *know-how* of the *everyday* whereby *Dasein* is familiar with the world and the equipment in it (Heidegger 1962). For the participants, this is the *comfort zone* which, for the most part, is below the level of consciousness. Accessing this knowledge base is done in an automatic way. This relates to the *fore-having:* "In every case an interpretation is grounded *in something we have in advance* – in a *fore-having"* (Heidegger 1962, p.191/150*)*. Indeed, participants approach, experience, and respond to clinical

situations according to their *fore-having*. Exposure to regular clinical scenarios this *knowing-what* can be related to pattern recognition: "*I've seen this before…I know this now*" (AbiInt1). Abigail is describing the realisation of the confidence in her knowledge *now* that she is seeing something again and it has reinforced her knowing

Pattern recognition derives from experiential knowledge within the domain of practice (Estabrooks *et al.*, 2005; Rolfe, Freshwater and Jasper, 2001; Benner, 1984; Carper, 1978). An aesthetic way of knowing occurs when knowledge is a gathering process of scattered details and particulars of practice are combined into an experienced whole. It has also been related to immediate knowing (Jacobs-Kramer and Chinn, 1988) and professional craft knowledge (Titchen and McGinley, 2003). Fulbrook (2004) referred to pragmatic epistemology as practical knowledge which incorporates all forms of knowing. Thus, it incorporates the view that clinical experience and expertise, together with an eclectic approach to evidence-based-practice, leads to effective patient care and improved practice. Indeed, participants described their clinical reasoning as involving intuition, pattern-recognition and hypothesis-testing. These aspects also align with the literature (Ramezani-Badr *et al.*, 2009; Odell, Victor and Oliver, 2009; Cioffi, 2001).

Fonow and Cook (1991) point out that nursing experiences are socially constructed. References to concepts such as intuition being innate, mystical, cognitive, a feminine trait, decontexualised knowledge (Darbyshire, 1994) or as a mystifying phenomenon (Perez and Liberman, 2011) only highlight the need for more exploration. The findings from this study afford an interpretation from a phenomenological basis yielding a rich deep understanding of the lived experience

of how ANP's manage risk in practice from the perspective of those practitioners experiencing it. The participants in this study valued their non-linear ways of knowing or accessing their knowledge. Examples included intuition, pattern recognition, and hypotheses testing, particularly with regard to the context of limited time.

Participants described knowledge as being at the "*back of the mind"* and the "*front of the mind".* Thus, at the back of the mind is that comfortable knowledge base that when pulled forward to the front of the mind enables what is being seen to be processed and understood. How and why certain information was retrieved and not others is mediated by mood. An example of which is a participant who described how an emotive book recently impacted on his risk decision-making (WilInt1); this can be considered *availability bias* when something is readily available to one's mind (Hayes, Chatterjee and Schwartzstein, 2017). Cognitive bias are thought patterns that deviate from the typical way of decision making (Croskerry, 2003).

Conversely, there may be a presentation that is explicit, yet, can remain concealed: "The entities' encountered environmentally as closest to remain concealed" (Heidegger 1962 p.131/98). Thus, as familiarity of typical presentations increases and becomes ingrained in one's practice, the less conscious or aware ANP's are of their processes which make articulating what they do challenging. These subconscious processes are do not reveal themselves it because of their proximity of familiarity. Participants also describe the potential for "*missing something"*. When pattern recognition is used too readily, one can risk going down the wrong diagnostic path. Thus, revealing one possible diagnosis can then conceal

another possible diagnosis. In order to reveal it would need to be done with an intention or *care towards.* Heuristics (mental shortcuts) and cognitive bias cause rapid impression-based decision-making and can lead to errors (Henriquez and Korpi-Steiner, 2016). Training and education for bias avoidance is challenging (Hayes, Chatterjee and Schwartzstein, 2017)). However, Croskerry et al (2014) refers to debiasing through encouragement of consideration of alternative diagnosis referring to it as a movement towards mindful practice

For the participants in this study, awareness of a potential for risk happens when something does not fit or cannot be applied to their knowledge base. This is what happens when a situation presents itself, but something is not known or understood. This may be described by Heidegger as "Pointing out". This happens when the equipment is different or doesn't work, such as Heidegger's reference to a hammer that is too heavy (Heidegger 1962, p.196/154). This *fore-having* of knowing means that patterns of patient presentation enable *fore-sight* regarding what to expect in terms of the possibilities of any given situation. Ultimately *fore-conception* is the potential of interpretation of that understanding. Thus, when something is not understood, the deeper interpretation of this knowledge enables it to be revealed for future understanding of a similar situation. Heidegger refers to this as follows: "When something is understood but still veiled…." (Heidegger, 1962 p.191/150) a deeper understanding is "…conceptualizable though interpretation" (Heidegger 1962, p.191/150). Heidegger refers to this fore-conception as to "Grasp(ing) in advance" (Heidegger, 1962 p.191/150).

6.6.1 Seeking Understanding

In managing risk and safety, the participants discussed how they sought to make sense and understand presenting situations. Undoubtedly deductive reasoning and evidence-based practice is imperative for patient safety. Clinicians have been found to value non-analytic decision-making processes (Ghosh *et al.*, 2012; Offredy, 1998). Indeed, it has been found that experienced nurse practitioners have been found their use of non-analytic exceeded their use of non-analytic processes (Ritter, 2003). Tacit knowledge and intuition have been found to influence clinical judgement when the evidence was unclear. Welsh and Lyons (2001) study demonstrated ANPs have been shown to incorporate more system I (intuitive) processes, triggering system II (analytic processes) in comparison to doctors (Pirret, Neville and La Grow, 2015). Cabrera *et al's.* (2009) observational study on emergency physicians concluded that system I is insufficient for final decisions but provides a framework for system II decision-making. However, for the ANPs in this study, the subjective sensing of situations revealed was an intuitive searching in order to validate an often-unsubstantiated sense of an unknown risk. For these participants, rather than system I being a framework on which to build, it was more of a fluid process of deconstruction and reconstruction of knowledge and understanding.

The participants spoke of forming a picture using both objective and subjective information. There is a strong theme of "*seeing", "looking"* to "*build"* or "*create"* a mental "*picture"* of a situation to form a holistic understanding. In an attempt to give a deeper interpretation of this concept, a form of *sight* is referred to by Heidegger (1962) which is not to be confused with the traditional concept of

sight. He refers to a misunderstanding of the expression of *sight* stating that it responds to *clearedness.* "Seeing does not mean just perceiving with the bodily eyes, but neither does it mean pure non-sensory awareness of something present-at-hand in its presence-at-hand" (Heidegger, 1962 p.187/147). Thus it "allows entities which are accessible to be encountered unconcealedly in themselves" (Heidegger, 1962 p.187/147). Linking back to intuition, this is an attempt to reveal that which may be concealed or not yet known or understood. In an environment that values objectivity, decisions based on subjectivity may be considered irrational (Ozcan *et al.*, 2014)). Indeed, Perez and Liberman (2011) contends that decision-makers are left with nothing but a set of biases and heuristics, both of which are known to produce error. Rationalism suggests that knowledge can be obtained by reasoning, whereas empiricism suggests that knowledge is obtained through sensory experience (Clarke, 2010). Thus, the two dominant approaches to epistemology, rationalism and empiricism differ with regard to what constitutes the actual source of knowledge and the method by which knowledge can be attained; whether deductively, through mental constructs such as concepts, laws, or theories or inductively from particular sensory experiences (Nonaka and Takeuchi, 1995). Heidegger writes that "when irrationalism, as the counter-play of rationalism is blind, it does so only with a squint" (Heidegger, 1962 p.175/136). The meaning taken from this is the recognition that despite a seemingly irrational decision which shows little insight, it is perhaps merely a different way of viewing a situation or the only way of attempting to look at a situation. A *squint* is an attempt to view something difficult to see and might be viewed as using everything in one's own tool box of ability.

Participants described as ANPs having to "*work harder than their medical colleagues to prove themselves*" (WilInt1), and to "*jump through hoops*" (DiInt1) and provide objective evidence "*to be seen to be credible*" (TedInt1). Kinsale referred to the oversimplicity of rationalising a patient discharge "*based on normal vital signs*" (KinRef2). As discussed in Chapter Two, the role of ANP's was born not purely from nursing wanting to advance and develop their profession but as a workforce strategy to address the shortages of doctors and increasing demands on the health service due to population growth and more aging patients. For various reasons, this has happened both nationally and internationally (WHO, 2018). As a result, the nursing profession is advancing rapidly and those ANPs at the forefront are aware of a need to demonstrate competence, safety and rationale for their care (Oliver, 2017).

6.6.2 Interpretive Learning

The participants seeking to understand and interpret situations serves a further purpose of being able to rationalize decisions not only to themselves in the moment or after the event but also to be able to justify their decisions to others. For Heidegger (1962) "Intuition and thinking are both derivatives of understanding (Heidegger, 1962 p.187/147). Thus, "All sight is grounded primarily in understanding (the circumspection of concern is understanding as *common sense),* we have deprived pure intuition of its priority"" (Heidegger, 1962 p.187/147). When the knowledge base is not considered to be adequately equipped to deal with a given situation, the *call to care* is explained by Heidegger in the following way: "The caller is Dasein in its uncanniness: primordial thrown Being-in-the-world as the "not-at-home"" (Heidegger, 1962 p.321/276). This *being not at home* is

recognizing a certain discomfort in one's limitations and the unfamiliar to the everyday self in terms of those areas outside of the comfort zone. This was described by Di in the following way: *"That's not my bag"* (DiInt1).

A sense of concern and guilt precipitated deeper thought to move from a basic understanding to interpretation in order to assimilate new knowledge and learn from an experience that did not fit the previous pattern. Thus, those feelings of concern in managing uncertainty are part of a necessary process to learn from these experiences. "*We must learn from all experiences, good and bad*" (PhiIn2), "*If we stop learning we flatline*" (SteInt1). The moods and feelings of guilt and concern, are left unresolved and are there is a calling for them to be resolved, described as follows: "*sleepless nights"* (AbiInt1, CatInt1/2, WilInt1/2), "*he sat on my mind*" (DavInt2). The choice is to flee from learning when something is not your "*bag"* or to turn towards learning through reflection, or what Heidegger (1962) would term as *circumspection*: "To say that 'circumspection discovers' means that the 'world' which has already been understood comes to be interpreted. The-ready-to-hand comes *explicitly* into sight which understands" (Heidegger, 1962 p.190/149). Thus, to flee would discard, cut off or sever the learning opportunity. Heidegger refers to circumspective concern as *de-severing* and bringing-close from understanding to interpretation (Heidegger 1962).

If as these findings suggest, experiences of managing risk may be associated with learning and advancement of practice then arguably there needs to be a focus on healthcare outcomes. Potentially learning from risk must involve feedback on clinical decisions made, however without specific feedback processes in place is more difficult to achieve in emergency settings where patients move on quickly.

Indeed, feedback such as from incident reporting is considered essential for organisations to learn from near misses of mistakes particularly in high risk environments (Stavropoulou, Doherty and Tosey, 2015). Unfortunately, such feedback processes tend to focus on negative feedback rather than positive (Gary, 2013) Risk taking without a necessarily knowledge of outcomes, potentially poses a threat to patient safety (Black, 2014)).

The epistemology that defines Advanced Practice is either heavily focused on a scientific research base or is deeply embedded in practice (Rolfe, 1998). Arguably, it should include both of these elements. Indeed, the essence of advancing practice is the acquisition of new knowledge and skills to compliment previous theoretical and practical knowing. It is important to put the individual advancing their practice into the context of advancing nursing practice as a whole on a macro or global level (Christiansen, Vernon and Jinks, 2013).

Reconceptualizing one's knowledge base though iterative, interpretative cycles of interpretation and understanding aligns with the Heideggerian ontological belief that truth and knowledge are temporal and can only be understood from the perspective of *Dasein* (one's own existence). This cycle of interpretation means that it is "excluded for the domains of rigorous knowledge" and "must then be resigned to less rigorous possibilities of knowing" (Heidegger, 1962 p.194/152).

The essence of these findings is that the information achieved within the "*snapshot"* may often be sufficient in order to make a reasonable decision suitable for an emergency setting even when faced with uncertainty or limited information. This is particularly true with regard to the constraints of time and balancing one patient's risk against others waiting to be assessed and treated. Hall (2002) argues

that in situations of limited knowledge, generating more information does not eradicate uncertainty. Irreducible, uncertainty contributes to variations in clinical practice (Thompson, 2009; Eddy, 1984). Seeking to achieve standardised evidence-based practice has led to an environment that values rational certainty. For these participants conflict arose when seeking to manage risk on an individualised patient in today's healthcare context of complexity and uncertainty. Conceivably, true transparency needs to recognise this often-concealed area of practice.

Indeed, the participants spoke of an acceptance of the inevitability of risk and there is no single approach, each situation and each patient are considered unique. Heidegger (Heidegger, 1962 p.194/153) warns against sensing "this circle as inevitable imperfection and avoid it in seeking understanding or interpretation to a definite ideal of knowledge". Thus, by seeking a definite answer that can be applied to all situations, such as following the rules of others against one's own interpretation, one may conceal other possibilities.

It therefore emerges that the notion of ANPs does not recognize that these practitioners are actually *advancing* practice. This relates very closely to Heidegger's concept of *temporality* and can be seen as always looking towards the future. The very nature of *advancing* one's own practice or, indeed, the profession as a whole, is risk-taking in itself.

Dealing with risk is done through varying dispositions which have an impact on how it is approached and managed and how and if learning and development is achieved. Looking after, nurturing, and tending to the self and recognizing the emotional impact of the lived experience of risk will enable a maximized positive potential for managing risk. As Heidegger (1962) states so well: "Dasein can,

should and must, through knowledge and will become master of its moods" (Heidegger, 1962 p.175/136). On consideration of the below reflexivity (Figure 21), mastering moods is a questionable expectation.

Sept 2017 Harrowing disclosure *Whilst a theme for all, Dave was very expressive in discussing the angst and fear of maintaining patient safety on the conveyer belt of time. Compounded by internal and external pressures, lack of support and isolating seniority. "It's harrowing". Ethically responsible consideration of participants welfare was paramount and as with all participants, following the interview support mechanisms were discussed. Dave enjoyed letting off steam, talking help and he does that a lot. I was assured.*

Figure 21: Reflexivity Box 7

These findings suggest a need for ANPs to be educationally and emotionally prepared to deal with the complexity and uncertainty of practice with regard to managing risk, in order to gain self-awareness and facilitate ongoing support both within and outside of practice. Thompson (2009) believes nurses should be trained in responding to uncertainty rather than certainty, and that this should include debiasing through mindful practice (Croskerry *et al.*, 2014), reflective dialogue (Diekelmann, 2004), critical-thinking, hypothesising and intuitive decisions (Kosowski and Roberts, 2003) to aid dealing with inevitable information gaps (Perez and Liberman, 2011). As explored above, there are risks in not advancing practice and staying in one's own comfort zone. Whilst the participants described their experiences of being absorbed in and coping with risk in the now, it is the impact of

understanding possibilities in the future which is key to their development. However, a clearing needs to be made in order to learn and apply this learning to future practice.

6.7 Summary

These findings illuminate an alternative conception of risk according to ten ANPs working in today's clinical acute settings. This risk is temporal and balanced between not only multiple patients but also with the practitioners themselves. Through these findings facilitated a new perspective on caring in the context of ANPs managing risk and safety challenging traditional nursing conceptions of caring. Risk is managed from a perspective of care or concern towards a patient or situation.

Findings were that practitioners coped with risk according to moods, which both guided and hindered the participants management of risk and patient safety such as. Potentially channelling emotions such as concern, worry and fear may enhance capacity and capability to cope with risk and ultimately lead to safer care. Participants motivations of doing good and keeping patients safe from harm were the basis upon which the participants approached managing risk and safety.

How the practitioner's knowledge was retrieved, applied and new knowledge and experiences then assimilated was critical when managing risk; experiences of risk represent an opportunity to learn, develop and potentially advance practice.

Chapter Seven – Conclusions

7.1 Introduction

The findings of this study principally achieve a contribution to the theoretical understanding of risk from the perspective of ten Advanced Nurse Practitioners (ANPs) working in today's healthcare. Managing clinical risk and patient safety is high on clinical and political agendas. ANPs are frontline practitioners making critical decisions regarding risk and patient safety. Whilst research around nurse decision-making has been conducted, the extent to which ANPs manage and navigate patient safety and risk is under-researched. This lack of literature regarding the experience of managing risk and safety from the perspective of ANPs is extremely surprising when considering the current clinical and public focus in this area. This was identified as a gap in current research. Thus, this Heideggerian interpretive phenomenological study sought to reveal an understanding of the meaning of managing risk and patient safety to ANPs in acute settings with the aim of answering the previously unexplored question:

What is the lived experience of Advanced Nurse Practitioners of managing risk and patient safety in acute settings?

In order to answer this question, ten ANPs across three acute settings were recruited and iterative data collected over ten months on experiences of managing risk and patient safety through two reflective interviews and two written reflections. Data analysis was based on Van Manen's approach, which facilitated cycles of interpretation with each data source. The resultant collective themes

were: Conveyer Belt Environment; Coping with Risk on a Spectrum; Patient Sharing; Moods Fuelled by Fear; Information Seeking; and Knowledge Comfort Zone. These themes derived through this unique study design amplified an understanding of how risk and patient safety is experienced by these practitioners. The key findings are as follows.

7.2 Key Findings

The distinctive contribution to knowledge provided by this research is an insight and advancement of understanding of how today's ANPs experience managing risk and patient safety. Thus, the unique findings from this study have provided a new theoretical understanding of risk in this specific context. For the ANPs in this study, the management of risk and safety was experienced through a continuous awareness and balancing probabilities of potential risks according to individual contextual interpretation at specific moments in time. Risk was managed by understanding and responding to issues of patient safety through a shared negotiation with others. This involved an integration of existing knowledge with information available and according to emotional instincts and perceived capacity. For these ten practitioners, safe experiences of risk were an opportunity to expand knowledge and advance practice. The following key areas emerged from the findings and were discussed.

Re-defining risk

The findings of this study align with existing literature in terms of an understanding of risk as socially constructed (Ochsner and Lieberman, 2001; Giddens, 1994) and

the psychometric balancing of probabilities (Bourne and Robson, 2009). However, in addition to this knowledge, these ten ANPs collectively shed light on an experience of risk that is a socially-constructed phenomena requiring constant temporal negotiation with patients, colleagues and organisational structures. Patient safety is contextual and temporal and thus balanced with multiple other risks including professional risk to the practitioner.

Concept of care (intuiting risk and caring for self)

The findings of this study revealed a conflict with the traditional nursing conception of care in relation to the approach of managing patient safety. Caring as an emotional connectiveness to patients which has long been long associated to nursing (Ronald *et al.*, 2016), was not identified as an essential pre-requisite to effective management risk and patient safety. On the contrary, the *care* that emerged from this study was a sense or *concern-towards* an actual or potential risk of a situation, a specific patient, or for the practitioner themselves.

Instinct fuelled by fear

Nursing instinct and intuition is well established in the literature (Benner, 1985; Carper, 1978) and increasingly associated with dealing with complexity (Ghosh *et al.*, 2012; Rasmussen, 2012) and uncertainty (Lyneham, Parkinson and Denholm, 2008; Croskerry, 2003; Cioffi, 2001; Beresford, 1991). Indeed, the findings are broadly in line with existing models of decision-making, both linear and non-linear. However, whilst previous studies have indirectly linked intuition to risk (Bowen *et al.*, 2014), this study revealed an association for how these practitioners managed

risk guided by instinct, moods and emotions. Feelings of comfort, discomfort, worry, and fear were both drivers and barriers to coping with risk, which has implications for practice in terms of education and support.

Ethics of risk

The participants in this study identified a strong motivational factor when managing risk and safety which was the imperative of doing what is best for the patient. Ethical issues of beneficence, non-maleficence, paternalism and autonomy were raised and re-evaluated in light of these findings.

Comfort Zone of Knowledge - Seeking understanding, Interpretive learning

For these practitioners, if embraced safely, experiences of risk are an opportunity to increase knowledge and potentially advance practice. Literature that associates knowledge and risk is focused on such areas as: initial assessment, intensive care (Ramezani-Badr *et al.*, 2009), clinical prediction (Cabrera *et al.*, 2009), mental health risk assessments (Phillips, Stargatt and Brown, 2012; Welsh and Lyons, 2001) or comparison with doctors (Pirret, Neville and La Grow, 2015; Offredy, 2002). The findings align with the literature on established theories of formal and informal nursing knowledge (Benner, 1985; Carper, 1978) and the interplay with type 1 and 2 reasoning in the acute clinical setting (Pirret, Neville and La Grow, 2015; Bowen *et al.*, 2014; Van den Bruel *et al.*, 2012; Ghosh *et al.*, 2012; Ritter, 2003; Burman *et al.*, 2002). However, this research further illuminates how, for these practitioners, the way in which their knowledge is accessed and utilised, is crucial. This is with regard

to not only managing risk and patient safety, but also how, and to what extent, the potential for learning from experiences of managing risk is realised.

Thus, in summary, the findings unveiled that in an environment driven by time pressures, how practitioners cope with managing patient risk and safety is dependent on the presenting situation, breadth of knowledge-base, application of evidence, degree of perceived management support, and channelling of emotive moods. In situations of uncertainty, insufficient knowledge, and/or lack of information, practitioners were guided by care, concern, worry, feeling happy or comfortable and, in critical times, fuelled by fear. These feelings were illuminated to be both drivers and barriers to practitioners' capabilities in grasping patient presentations. Snapshot judgements made by practitioners were individualized and negotiated dependent on practitioners' and patients' capacity to cope with risk. Experiences of risk often identified a learning need or knowledge deficit, revealing an opportunity to develop and advance ANP practice.

7.3 Contribution to the Field

The main contribution of this doctorate to knowledge is a unique insight into the collective lifeworld's of ten ANPs managing risk and safety working in today's acute settings. This insight illuminated a conception of the phenomenon of risk as a socially constructed negotiation between practitioner, patient and healthcare organisational structures, all temporally situated in a context of continually changing clinical priorities.

The ANPs in this study illuminated a new conception of care in the context of managing risk, which challenges the notion of caring in the traditional nursing sense. In this specific context, *care* was more a *concern towards* either a situation, patient or also perhaps, the practitioners themselves.

In addition, this study has shed light on the significance of the role and impact of moods and emotions in decisions about risk, particularly at crucial times of complexity, uncertainty and limited time. These findings support the links in the literature between the use of intuition and heuristics with coping with clinical uncertainty. However, findings regarding the impact and the role of mood and emotion, in terms of how ANPs manage risk, has not previously been illuminated.

Furthermore, the findings of this study have highlighted the ethical position of ANPs managing risk and patient safety in today's risk aware healthcare context. The moral imperative of *doing good* and no harm revealed conflict between patient empowerment and autonomy with paternalistic and professional expertise; particularly as risk was found to be a shared phenomenon, which required careful negotiation between multiple perspectives.

Finally, the participants in this study identified that, if embraced safely and with support, experiences of managing risk and patient safety can be an opportunity to learn and advance one's own practice and ultimately lead to safer patient-centred care.

7.4 Conclusion

The findings of this research are clearly placed within a healthcare system which is seeking to re-address a lack of trust and concern about risk and safety. Recent

high-profile health safety failings have led to a mistrust of professional expertise and increased regulation. Professionals are required to be more explicit for accountability, auditing performance and procedures designed to minimize risk (Trinder, 2008). Arguably, the political and public thrust behind safety directives have not taken into full account the reality of practice. The lived experience of ten ANPs, who are advancing their practice in this context, proves a unique insight. The value of these findings that illuminate this area of practice enables a required transparency within a culture in which openness and learning from outcomes and feedback is essential.

7.5 Limitations

There are, however, limitations to these findings. Firstly, they are derived from a homogeneous sample of ten ANPs who work in acute settings in one area of the country which limits generalisability and also has potential for bias (Palinkas *et al.*, 2015). Indeed, it is possible that participants from other areas with a different patient demographic, service demand and organisational culture may well have achieved different findings. An attempt to broaden the spectrum was enabled by sampling from three different acute settings. The participant gender ratio was equally balanced with five males and five females. However, the specific impact of the varied level of experience in relation to expertise was not directly explored with each participant, as this was not within the realms of this study. Despite limitations, this homogenous group was beneficial in achieving deep insights and rich data through a direct focus on the lived experience the phenomenon (Kosowski and Roberts, 2003).

Another limitation is the use of interviews. Interviews may be considered a weak form of data collection as it is assumed they achieve an accurate and true picture (Fontana, 2008). Reliance on self-reporting of participants lacks generalizability, rigour and is prone to bias (Jensen and Rodgers, 2002). Follow-up exploration of outcomes of these risk experiences would have provided comparative insight of perceived effectiveness of risk management but not within the realms of this study. Despite the limitations of interviews, the use of multiple data sources, including two interviews and two written reflections over a period of time, added more credibility than a single interview situated in a specific context and time. However, it is necessary to consider that an alternative design such as a shorter or longer time interval between interviews/reflections may have achieved differing results. Although the time frame chosen was effective, a shorter one may have facilitated greater intensity and a longer one would have drawn out greater changes over time. Taking the themes back to the participants would have enriched and enhanced the findings.

Whilst I employed methods to secure rigour and trustworthiness, arguably the study is also limited to my capability as a researcher, interviewer and analyser and how themes were derived. Nevertheless, this is the very essence of Heideggerian IP, an approach which brings the uniqueness to this study. However, it is also this approach that itself may have limited enquiry and is explored below.

7.6 Application of Heideggerian Philosophy

Within the conclusions of this study, it is important to reflect on the choice, use and application of the philosophy of Martin Heidegger (1962) as a philosophical lens

through which to structure the research. Whilst I believe it is imperative to align with a chosen epistemological and ontological perspective when carrying out phenomenological investigation, the choice to attempt to directly apply such a philosophy that is renowned for being a challenge to read and grasp for the novice philosopher, may be questionable.

The text of Heidegger (1962) translated from German is complex, long and contains many hyphenated phrases and entities that need to be comprehended. However, Heidegger's philosophy connected with my own ontological understanding in the world. Whist it remained a challenge to communicate with words through discourse and writing, its' principles and approach guided me through this process to a level of depth I believe I would not otherwise have achieved. This level of depth afforded me interpretations far beyond description and basic understanding. This theoretical underpinning allowed me to access data that may have remained concealed if another approach had been used.

The challenges lay in communicating and making this meaningful beyond my own experience of its' application. Whilst this is the greatest challenge of Heidegger's philosophy, it is also the essence of this philosophy that recognises that the closer in proximity that objects, or indeed beliefs, become, the harder they are to articulate through the inadequacies of language. Application of another approach such as that of Gadamer (1982) is considered a more accessible practical approach (Fleming, Balaguera and Craven, 2001). Indeed, this dialogical approach, may have achieved significant insights necessary for a study of this kind. However, I uphold that direct use of the Heideggerian Interpretive Phenomenological approach enabled me to *bring-close* authentic Heidegger without interpretation of *Others*. Despite the

challenges, it has enabled sufficient insights and advanced knowledge into this little-known area of practice.

June 2018 Am I married to Heidegger?

Am I married to Heidegger? I was asked today. Good question. Am I?....The simple answer- no. I am married to my husband….but does that mean I agree with everything he says? Of course not. If marriage is a commitment, then yes at some point early on in this PhD journey I made that commitment following careful consideration or constant re-interpretation since. Previous positive relations with Phenomenology helped getting to know Heidegger, a journey of confusion, self-interpretation and revelations. Alternative philosophical eyes may have been a good match but may not have revealed me to me, my fears, my temporality, the inevitable temporality of my patients. Heidegger cleared a space to indulge a concern-towards and illuminate an interpretive understanding worthy of the 10 participants whose time they gave Being-with me in this shared experience.

Figure 22: Reflexivity Box 8

7.7 Final Reflexivity

This research is a product of shared interpretation between myself as the researcher and the participants in my study. Throughout this thesis I have shared excerpts of the reflexive journal I have kept. These were to illustrate my interpretive presence of *Being* throughout the process of this research. As with IP, and as an insider, I bring my background, perceptions and interests (Krefting,

1991). I am a key part of the research process and it is through my unique perspective that this research has evolved.

The personal, emotional and intellectual resilience required to complete this thesis has been beyond a level that I had anticipated. However, the keeping of a reflexive journal throughout has been cathartic and illuminating. It ensured that specific insights and discoveries were not lost (Gerstl-Pepin and Patrizio, 2009). Diarizing thoughts, ideas, plans, hopes, worries, achievements and failures has afforded deep reflexivity, superficial insights, and a log of endless iterative interpretations that made me stop, reflect, write my thoughts and often capture an image.

A specific element of self-discovery was the need for me to capture literally *"snap-shots"* or moments in *time* that related to moments or Eureka, or to capture the *everyday* mundaneness of sitting in the library, to moments of philosophical elation of insights of deep interpretive understanding.

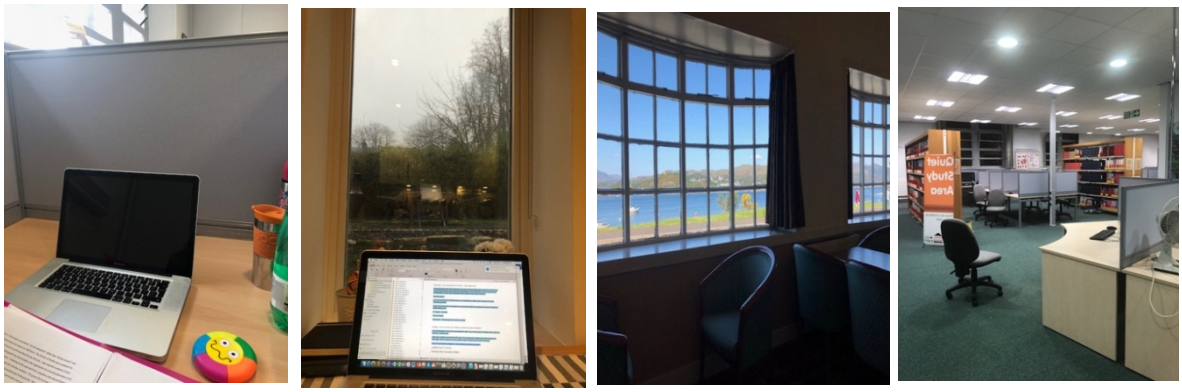


Figure 23: "Snapshots" and Moments in Time of the Everydayness of this Research

The everydayness was *Being* with my computer, going to the library, maintaining proximity to life outside the window, sun, rain, light and dark changing with the passing of *time*. I was surprised how comforting and safe *Being* alone felt to someone who loves *Being with others*.

Figure 24: My Everydayness of Being

There was authentic mindfulness of essential daily running, creating a *clearing*, opening my eyes anew to possibilities *in-the-world*, and a constant reflexivity and capturing of sudden moments of enlightenment. The shadow shows I am there *in-the-world.*

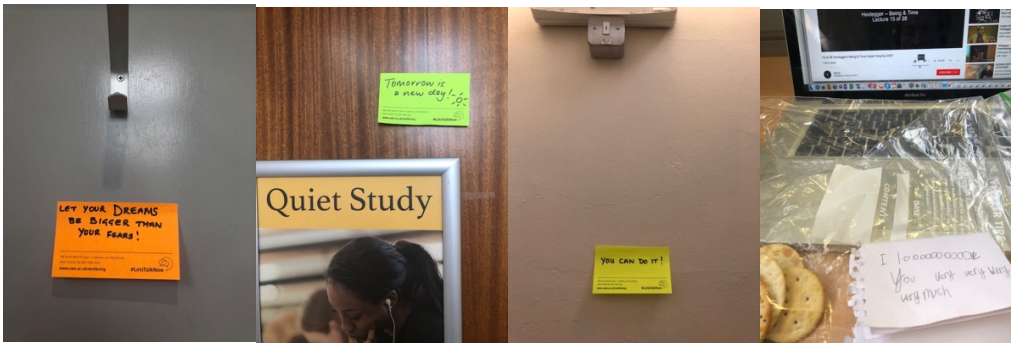


Figure 25: The Inauthenticity of Being Alone

Reflection was on the *inauthenticity* that despite my isolated existence of *Being*-alone, I was still affected by *Others.* Examples included selectively *Being-towards*

messages from unknown *others* that resonated, and the generosity of my children, (very much known O*thers*) with words and food to fuel me through my fear of impossibilities.

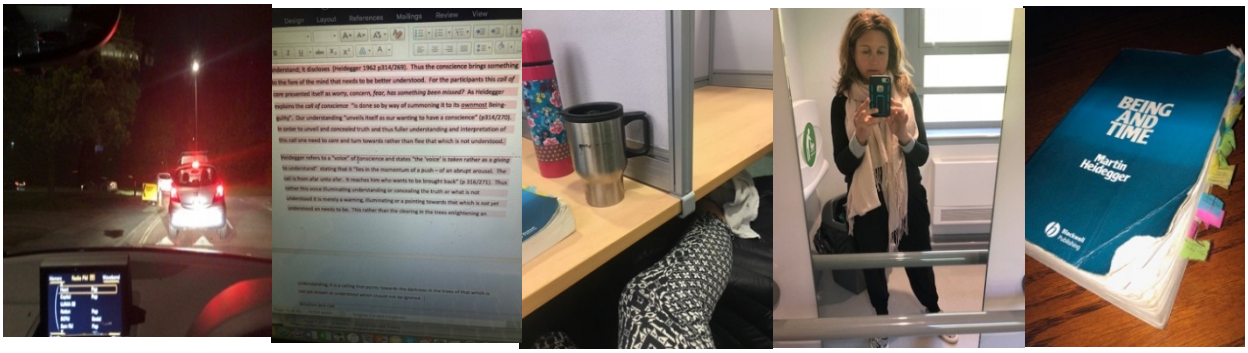


Figure 26: Overcoming Barriers

I also reflected on: overcoming barriers; achieving come-back from feedback; ankle-elevation in the library; lack of time; moods of concern, guilt, fear, self-doubt – questioning my reflection - why? Furthermore, I reflected on feeling unsafe, out of my comfort zone, uncomfortably taking risks with Heidegger …excited, exhilarated, learning, advancing, driving forward, alive.

These are all moments of my *Being* and *time* and illuminate the perspective from which I lived the experience of this research process from a constantly changing perspective within the passing of time.

7.8 Implications

The experiences that were represented and shared in this thesis were done so with the intention of achieving an insight into a selection of lived experiences that might resonate with others in this field of practice. The value of expanding knowledge and

illuminating the lived experience of how ANPs manage risk and safety in practice is imperative if the concerns regarding healthcare of today's risk society are to be addressed.

These findings have implications for the healthcare policy, preparation, training, teaching, education and development of ANPs. Furthermore, the findings also have implications for the provision of ongoing support within practice, with regard to facilitating the learning and development of experiences of safely managing clinical risk. Additional implications are with regards to recognising the emotional toll that managing risk has for ANPs and providing the necessary preparation and support. All of the above not only will achieve safer patient care but could ultimately have a positive impact on recruitment, retention and general wellbeing of these crucial healthcare professionals.

This research looks specifically at how ANPs manage risk and patient safety in acute settings. The findings sit in a developing body of literature which has a place within the current healthcare policy context. This context is within urgent and emergency care policies, such as the *Five Year Forward View* (DH, 2014) and the *NHS Long Term Plan* (DH, 2018). The critical aims of which are to provide fast, safer, better urgent and emergency care services (see Chapter Two). It fundamentally aims to develop primary care services to relieve pressure in emergency settings which involved the development of roles such as ANPs. The findings of this study should help to inform the national policy agenda of HEE in reference to the preparation, education and support of ANPs and ACPs. This includes specific policies such as *Workforce Planning and Development, Improving Public Safety and Quality in Health Care, Assessing and Responding to Patient Risk and Learning from Incidents*

and Public Engagement Strategies (HEE, 2017). Thus, this work strives to contribute to and facilitate the operationalisation of current UK policy. This research offers an insight into the experiences of ten ANPs working in today's clinical settings and can inform policy makers of the future as how best to achieve aims and support these practitioners to manage risk and patient safety. This support must incorporate ANP needs, educationally, clinically and emotionally.

Facilitating operationalisation of current and future policy requires support and collaboration not only between organisations but also individual clinicians. How effectively this is facilitated, ensured or enforced, and how ANPs are educated, trained and supported is dependent upon the depth of understanding of experiences of those clinicians working at the forefront. These findings highlight the importance of education and support around managing risk in practice that should inform the National Policy agenda of the HEE. Policies regarding standardisation of the ANP role, education, training, ongoing support, monitoring and development is imperative to enable ANPs to practice safely.

The challenges of meeting increasing healthcare demands on ANPs who are under pressure to provide high quality, timely and cost-effective care has implictions for recruitment and retention. The increasing volume, complexity and expectation of patients are added pressures which are evident in the findings of this study. Policy documents regarding workforce planning and development identify non-medical practitioners as a key to the future workforce planning. These documents refer to ANPs requiring varying levels of supervision which should be done on an individual basis. The more recent policies within the *NHS Long Term Plan* (DH, 2018) have moved towards an emphasis on ACPs in workforce planning. The newly

developed ACP standardized education pathway highlights the importance of responding to national consultations on speciality specific competencies. It is clear that preparation and education of managing risk has a key role to play in not only supporting national policy agenda but individual clinicians themselves.

Policy initiatives such as the *Care Quality Commission Public Engagement Strategy* aims to consult the public and involve them in policy decisions to achieve fair, transparent care. However, this strategy additionally needs to take into account the perspective and experiences of clinicians to address the issues of risk. Risk as a concept needs to be understood from the perspective of ANPs as a shared negotiated risk with patients. This element is imperative to achieve an appropriate, fair, safe and realistic expectation of care. Linking both public and clinician engagement strategies may potentially enable shared transparency of the reality of manging risk and safety. Thus, working together in a less 'them and us' way recognising the collaboration and shared perspective that seems to be the reality of practice for the ANPs in this study.

The policy documents *Improving Quality and Safety in Health Care: Assessing and responding to patient risk and learning from incid*ents (see Chapter Two) go some way towards setting out a blueprint for this area of practice. However, a key factor in emergent and urgent care policies is self-care and patient autonomy. If this is to be holistically promoted, then it is essential that decisions regarding risk cannot be reduced to a quantifiable level. The emotional or subjective component of both patient's and ANPs approach to risk are clearly factors. Thus, the grey areas such as a self-determining, fully informed patient negotiating a risk with a clinician needs to

be not only well documented but transparent and shared collaboratively. These grey areas need to be recognised by policy makers.

In order to be transparent, safe and collaborative, it is important to raise the profile of the reality of this practice. This can be done through patient education, health promotion, advocacy and closer working with patient engagement groups. Based on the findings of this research and the societal, clinical and policy context in which ANPs currently manage risk and patient safety, the following recommendations are made:

- Education, preparation, on-going support for ANPs including scenario training preparing ANPs to manage risk
- Decision support systems which recognise subjective and emotional components with explicit documentation of accountable collaboration on risk decisions. This includes further development of guidance on how to document shared deviations
- Interprofessional support involving mentor/peer buddy working scheme to enable a skill mix of reciprocal junior and senior support
- Enhanced feedback systems, including both positive and negative outcomes, learning from shared experiences, mistakes, near misses. Closer links with education and identifying ongoing learning needs and development
- Debriefing training/Reflective sessions. Support for practitioners – recognition of emotional impact of managing risk
- Patient involvement, education to increase understanding of how risk interplays in healthcare decisions made by professional's through

patient education, health promotion, advocacy and closer working with patient engagement groups

- Media involvement giving ANPs a voice, profile and engagement

It may be questioned whether these recommendations are part of a workforce enabler or driver to policy implementation and change. It is the intention that the findings of this research can and indeed should contribute to all of the above. This new knowledge derived out of the experiences of ten ANPs needs to be incorporated into the future policy. The *Five Year Forward View* (DH, 2014) and the *NHS Long Term Plan* (DH, 2018) go some way towards forging the path of safe, effective and integrated care between services. However, this foundation must be projecting towards the longer-term view that builds capacity and capability for sustainable, realistic and safe quality improvement in this area of care. Future policies need to incorporate strategies that bring together differing conceptions of risk and patient safety that recognise and support safe and transparent practice for both patients and practitioners.

7.9 Recommendations for Further Research

As a result of undertaking this small study, whilst it has shed light on this area it has moreover opened further areas for enquiry in order to address these gaps in understanding. Indeed, it is anticipated these findings will inform post-doctoral activities of investigating ANP management of risk on a larger scale to investigate whether this shared experience of themes relate to the wider community of ANPs. The following are recommendations for further study:

- A third interview to take the themes back to the participants for validation
- Questionnaires/focus-groups to share themes with a wider ANP community (other locations/settings)
- Repeat the study with mixed-method of both qualitative and quantitative including outcome variables
- Repeat the study, larger sample size, different area of the country, investigate gender, ethnic, age or experience differences
- Phenomenological enquiries into *care* and *fear* relating to risk
- Comparison studies with acute care settings that have the recommended implementations (positive feedback processes, debriefing, buddy working schemes) in place and those that don't – does this make a difference?

Further thoughts regarding future study is the potential for a longitudinal study of the same design extended over a longer period of time, such as over five years would also provide much greater insight and allow an illumination of how training and practices shift in line with new societal issues and the subsequent new policies. I would also recommend doing a comparative study including other similar professions such as paramedics, pharmacists, physiotherapists, and radiographers, who also carry out these roles in the urgent care settings to reflect the nature of multidisciplinary practice.

Finally, in retrospect, in view of the nature of the interviews, the descriptions and interpretations involved vivid descriptions of visual analogies worthy of further investigation. Discourse of imagery during the interviews accompanied by enthusiastic gesticulations aided shared imagery. Indeed, Heidegger (1962) referred

to the inadequacy of language to represent and articulate the lived experience. There was therefore the opportunity for a deeper level of insight if this imagery and these gesticulations had been investigated further; perhaps through videoing the interviews to have enabled deeper analysis.

7.10 Dissemination

In order for these findings to inform future practice of ANPs, these findings need to be disseminated. The recommendations to practice will be shared to those participants within the study and the three organisations from which the research was derived, as previously agreed. The thesis will be uploaded and available on the University of the West of England's research repository. It is the intention that the findings of this research will be shared with specific authors, researchers, colleagues, and organisations that I have contacted through the process of this research from both within nursing and other high-risk professions (paramedics, aviation, military). An early abstract from this research was used at multi-professional conference in which the focus was managing risk and enhancing safety for professionals who work in areas of high risk. It is my intention to develop a series of publications aimed at peer-reviewed journal such as the Journal of Advanced Nursing and I intend to present my research at the British Society for Phenomenology Annual conference.

7.11 Concluding Comments

Current public and health policy focus on risk and safety in healthcare has resulted in a heightened public and professional concern around this area. This has caused increased pressures to ANPs working in this area. Managing risk and safety in this

context is an experience that discloses interconnected temporal and spatial meanings. The understanding and the perspective from which ANPs view risk, based on how they utilise and access their existing knowledge base and experience risk though their moods and sensing situations, is key to their lived experience of this phenomenon. An understanding of the emotional impact and the preparation, education, training, and ongoing support for ANPs in managing risk and safety in practice needs to be coupled with patient education and raised awareness of risk management in healthcare. This should lead to patients themselves being better prepared for taking responsibility of sharing informed decisions regarding the inevitability of balancing risk and safety decision in practice which will ultimately lead to safer patient care.

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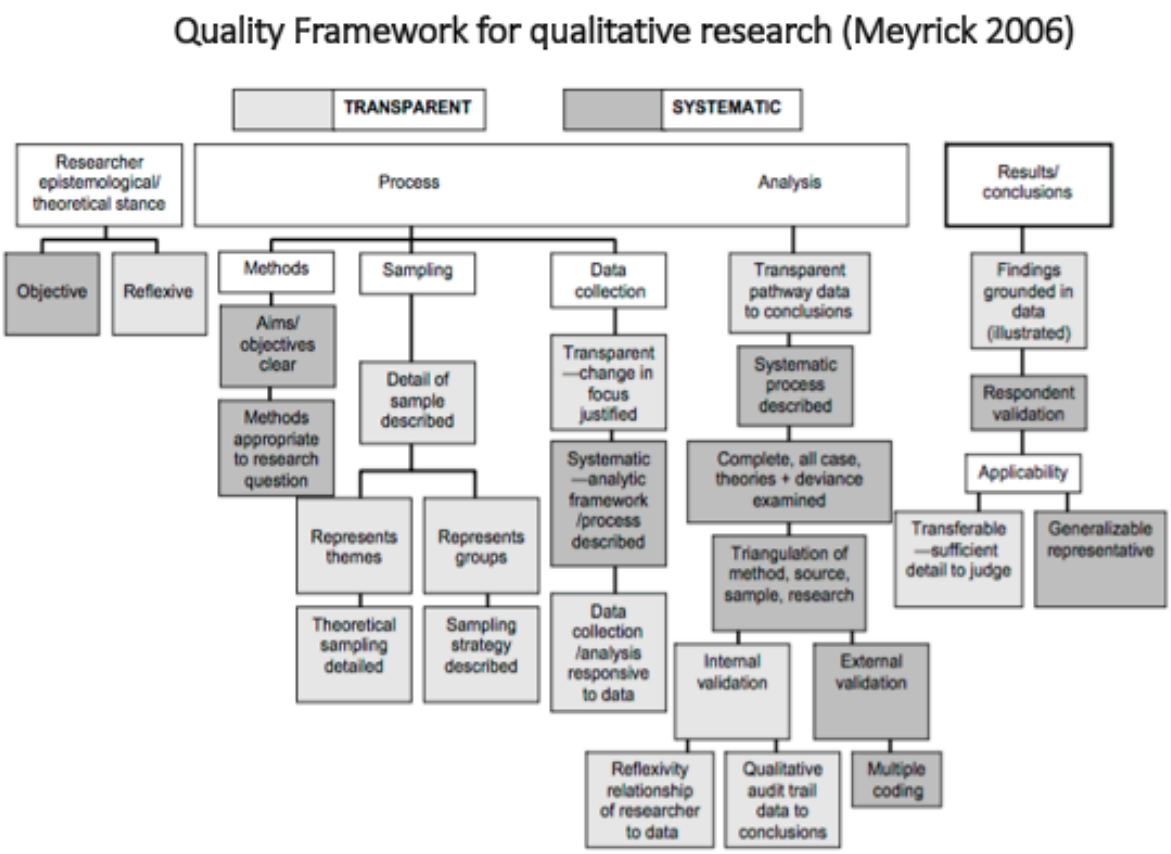
APPENDICES

Appendix 1 – Qualitative CASP Framework

1. Was there a clear statement of aims of the research?
2. Is qualitative methodology appropriate?
3. Was the research design appropriate to address the aims of the research?
4. Was recruitment strategy appropriate to the aims of the research?
5. Was the data collected in the way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous
9. Is there a clear statement of findings?
10. How valuable is the research?

(CASP, 2016)

Appendix 2 – Quality Framework for Qualitative Research (Meyrick, 2006)



Appendix 3 – Summary of Key Studies

Reference	Subjects/Population Setting, Sample Size	Data Collection Methods Interventions	Aim	Outcome/Conclusion
Pirret Neville and Grow (2015)	30 Nurse Practitioners (NPs) and 16 resident doctors in New Zealand Purposeful sampling.	Comparative research design. Used an intuitive/analytic reasoning instrument and maxims questionnaire. The measure of diagnostic reasoning ability/ accuracy used the maxims questionnaire using a 5-point Likert-type scale to explore the use of 13 maxims in participants' daily practice which enabled a score indicating clinical reasoning style allowing for direct comparison of doctors and NP.	To compare 1) the diagnostic reasoning style of 30 nurse practitioners (NPs) and 16 resident doctors and 2) its influence on their diagnostic reasoning abilities of a complex case.	The results showed NPs incorporated more system I (intuitive) processes when compared with residents; however, both groups identified with certain maxims. Diagnostic reasoning style was not related to participants' diagnostic reasoning abilities, indicating they triggered system II (analytic) processes when required. Diagnostic reasoning style and identification with maxims did not influence their diagnostic accuracy of a complex case.
Bowen *et al* (2014)	15 Paediatric Emergency clinicians in a Children's	Qualitative semi structured Interviews	Examining the decision-making of	Senior clinicians were identified to effectively manage clinical risk

	ED department in South West of England	using – self report methods of decision making in ED	emergency clinicians aiming to confirm if more children could be managed in primary care to reduce hospital admissions.	using high levels of intuition when applying guidelines to practice, linking expertise and increased risk-tolerance.
Cabrera et al (2015)	Emergency physicians assessing patients in the emergency department, obtaining 662 observations from 289 patients.	Prospective observational study of emergency physicians assessing patients in the emergency department.	Aimed to compare the performance of these system I and system II processing in determining patient acuity, disposition and diagnosis.	Results: For final disposition, the observers made a correct prediction in 80.8% of the cases. For ICU admission, emergency physicians had a sensitivity of 33.9% and a specificity of 96.9% The correct diagnosis was made 54% of the time with the limited data available. Concluding System I decision-making based on limited information had a sensitivity close to 80% for acuity and disposition prediction, but performance was lower for predicting ICU admission and diagnosis. System I decision-making appears insufficient for final decisions in these domains but likely provides a cognitive framework for System II decision-making.
Rasmussen	49 clinicians including	A qualitative study,	To explore how	Variations in practice, guidelines

(2012)	both doctors and nurses in one acute NHS hospital.	using a single case study methodology. Methods used included non-participant observation (184 hours), informal conversation, interviews (49) and a document review. An adapted version of the topic guide developed by **(Michie, van Stralen and West, 2011)** based on their theoretical framework of behavioural change was used in the interviews. Data collected were analysed inductively using NVivo	protocols and guidelines are used in the management of the risk of healthcare-associated infections.	were "worked around", improvisations made, staff struggled against organisational constraints, unrealistic conflicting priorities and protocol ambiguity. Four themes: ambiguity, organisational issues, professional frustrations and perceptions of contamination. Clinicians were detached from protocols/guidelines relying on informal knowledge to guide practice i.e. experiential knowledge, common sense, intuition, ''rules of thumb'' and "mind lines''. They also took account of preferences, their perceptions of risk, social norms and other contextual issues. Michie et al's (2005) behavioural framework does not seem to take into account tacit and experiential knowledge.
Phillips et al (2012)	Clinicians working in a psychiatric unit with 193 adolescent psychiatric patients (aged 13-18 years old) were included in retrospective analyses.	A retrospective review of patient records was conducted at the Marian Drummond Adolescent Unit Information collected	To examine the predictive validity of unstructured clinical risk assessment and associated risk factors for aggression in	Based on professional expertise, prior experience and intuition, clinicians are relatively good predictors of other-directed aggression in adolescent inpatient units.

		included admission risk assessment ratings, aggressive incident reports, patient diagnoses, sex and history of aggression and self-harming behaviour.	predicting self- and other-directed aggression in the first four weeks of admission for patients admitted to an Australian adolescent psychiatric inpatient facility.	However, they are less successful at predicting self-directed aggression in this population. It is possible that, unlike other-directed aggression, self-harming behaviour is heavily dependent on environmental factors and that admission to the inpatient unit removes these triggers from the individuals' environment.
Van den Bruel et al (2012)	Clinicians Acute Primary care settings, Flanders, Belgium.	Observational study. Consecutive series of 3890 children and young people aged 0-16 years presenting in primary care. Of the 3369 children and young people assessed clinically as having a non-severe illness, six (0.2%) were subsequently admitted to hospital with a serious infection.	To investigate the basis and added value of clinicians' "gut-feeling" that infections in children are more serious than suggested by clinical assessment.	Intuition and gut feeling was that something was wrong despite the clinical assessment with increased risk of serious illness (likelihood ratio 25.5, 95% confidence interval 7.9 to 82.0) and acting on this gut-feeling potentially can prevent 2 of 6 cases being missed (33%, 95% confidence interval 4.0% to 100%) 44 false alarms (1.3%, 95% confidence interval 0.95% to 1.75%). The gut-feeling was associated with the children's overall response (e.g. drowsiness), abnormal breathing, weight loss, and convulsions. A strong contextual factor was the parents' concern

				(odds ratio 36.3, 95% confidence interval 12.3 to 107).
Ghosh et al (2011)	Clinicians in a Computerised Tomography (CT). Scans in 390 head-injured children. In the UK	Qualitative and quantitative (mixed methods). A retrospective case note review was carried out of all patients under the age of 16 years presenting to the emergency department with head injury in 2007. The number of CT head scans actually performed was recorded, and the number that would have been requested using the hospital guidelines and the 2007 NICE guidelines was calculated.	Aimed to quantify the impact of NICE guidelines (2007) on Computerised Tomography (CT) scans in 390 head-injured children.	Findings found a three-fold increase in CT scans when following the NICE guidelines. Findings also identified less experienced clinicians relied on guidelines to achieve "safe" decisions, concluding that guidance combined with clinical expert intuition was invaluable.
Offredy (2002)	Compared the diagnostic reasoning processes among 11 general medical practitioners and 11 NPs.	Methodology using the think-aloud, scenario-based interview process.	To ascertain the differences, if any, in the decision-making processes of nurse practitioners and general practitioners	Both groups used the nonanalytic process of pattern recognition as their main decision-making method.

			for diagnosis and treatment when given the same patient scenarios.	
Welsh and Lyons (2001)	Eight Psychiatric nurses	Exploratory case-study. Data from 29 risk assessments and eight interviews.	To Investigate how psychiatric nurses using formal and other knowledge for a holistic patient assessment to guide care-planning.	Three themes: research knowledge, tacit knowledge and experienced practitioner skills. Tacit knowledge influenced clinical judgment when the evidence was unclear. Consideration of complex issues, as part of the risk assessment demonstrated levels of knowledge, skill and experience were important concluding that standardised mental-health risk-monitoring could only form *part* of a holistic assessment as most measures don't reflect dynamic nature of situations. Experienced practitioners push the boundaries of practice protocols/procedures using tacit knowledge and intuition as well as formal knowledge
Ritter (2003)	Ten experienced NPs	Used think-aloud protocols while working through a case scenario.	To examine whether the Information Processing Model or the Hermeneutical	The results determined that the NPs use of a nonanalytic process only slightly exceeded their use of the analytic process, again

			Model or a combination of the two models best describes expert nurse practitioners	confirming the use of dual process reasoning.
Burman, Stepans, Jansa, and Steiner (2002)	36 NPs	Qualitative study; asked to reveal their diagnostic reasoning processes through two clinical scenarios.	to explore the process primary care NPs use in making clinical decisions and the factors that influence the process.	Dual process of diagnostic reasoning was described

Appendix 4 – Data Extraction Template (Bowen *et al., 2014)*

Review topic: managing risk and patient safety

Reference:	Bowen, L. Purdy, S., Lyttle, M., and Heawood, A. (2014) The transition to expert: a qualitative study exploring clinical decision making for children under five attending the emergency department with minor respiratory conditions. *Emerg Med J.* 31, pp. 791.
Reviewer: Date Appraised:	J Girdher July 2016
Evaluative Summary:	Interviewed 15 Paediatric Emergency clinicians examining their DM aiming to confirm if more children could be managed in primary care to reduce hospital admissions. Senior clinicians were identified to effectively manage clinical risk using high levels of intuition when applying guidelines to practice, linking expertise and increased risk-tolerance.
Eligible?	Y
Typology	Qualitative
Participants	15 Paediatric Emergency clinicians
Study Aims	Exploring clinical decision-making for children under five attending the emergency department with minor respiratory conditions
Key Findings	Senior clinicians were identified to effectively manage clinical risk using high levels of intuition when applying guidelines to practice, linking expertise and increased risk-tolerance.
Evaluative Summary	This is a key article for the systematic review as it identifies the use of the use of non-linear knowledge to risk management
Methods	
Type of Study	Exploratory Qualitative research, Semi-structured interviews
Duration	Six months
Area/setting	Paediatric ED. Children's hospital with a standalone PED
Sample	Doctors, Emergency nurse practitioners and registered nurses with varying levels of experience.

Inclusion Criteria	Sampling – several strategies used to maximize, recruitment and participation, involvement of a gate keeper, chain sampling, opportunistic and theoretical sampling. Theoretical sampling used towards the end to target participants at particular levels of experience to further examine issues relating to emerging data.
Exclusion criteria	Limited exclusion criteria – not clear, initially opens net wide and then was targeted
Number	15
Appropriateness	I would question why nurses were included in the study with regard to if they are non-autonomous practitioners or the decision-makers; if so, their value to this study may be limited
Data Collection: Methods	Semi-structured interviews asked to reflect on two incidents where they were responsible to the care of a child in the ED with a respiratory illness. A definition of a "minor respiratory illness was not provided" left open to interpretation. Data was collected until saturation had been identified.
Role of Researcher	Team of four researchers, led by the main research to undertake the research and carry out he interviews, data analysis and write up.
Fieldwork	The research spent time in the field, recruiting and carrying out interviews.
Data Analysis	Analysis was conducted alongside data collection. By interview ten, the principle themes had been identified and were tested in subsequent discussions which aided shaping of themes and sub themes. Thematic analysis constant comparative technique. Open coding of transcripts by the first author.
Research Bias	Data analysis supported by NVivo 9. Each interview transcript was reviewed by two further researchers to enhance trust worthiness, evolving coding framework, discussed as a group. Participants offered transcripts to amend
Reflexivity	Good level of reflexivity with the involvement of the other researchers through the process, using an independent analysis tool as an adjunct to thematic analysis and coding, the use of the two further researchers to read the transcript and in development of the themes. Used an inductive approach. Involvement of the participants in offering the opportunity to review and amend the transcripts. The regular meetings with the researchers to discuss the emerging themes would also add to reflexivity.
Outcomes	12 themes identified
Findings:	

Themes	The three main themes (12 themes in total) of clinicians decision-making approaches: 1. Perception of factors influencing decision making (including a sub theme of risk management) 2. Assessment of severity (clinical observation to support decision making) and Observation of clinical signs, patients' appearance, behaviour, clinical intuition 3. Transition to expert (decision making skills according to experience) sub themes, clinical knowledge, colleague support, risk tolerance and intuition.
Conclusions	Managing risk was central in discussions about clinical decision making. Risk was described by participants as balancing the safety of the patient (typically ensured by admission) against the possible hazards, associated with discharge and deterioration. Clinicians initially relied on good clinical knowledge and awareness of guidelines as a foundation. Clinical experience allowed clinicians to experiment with risk and development of intuition. Clinicians working in the PED use a combination of clinical rules, supplemented by additional skills of observation, risk management and intuition to achieve clinical decisions in cases involving acute respiratory illness in children younger than five. The supplementary skills of observation, risk management and intuition develop over the course of training and are used to good effect by experienced clinicians to arrive at rapid treatment decisions.
Opinions	This was a study in response to the rates of paediatric admissions for respiratory illness persistently high to find out if they can be managed in primary care, decision asking about admissions is "unexplored. Greater understanding of issues from urgent care settings is needed
Policy/practice: Generalisable	Efforts should be directed towards training healthcare professionals in other settings to develop the skills of observation, risk management and intuition identified to support management of children outside the ED.
Implications for Policy	Consideration is needed on the pressures of clinicians to admit/discharge patient
Implications for Practice	Recognition of the context I which clinicians' practice and the impact the experience has on the way decisions are made.
Links to other References	Van den Bruel A, Thompson M, Buntinx F, Mant D: Clinicians' gut-feeling about serious infections in children:

	observational study *BMJ* 2012; 345 Contacted the key researcher directly to discuss the study and she shared a further reading list and we talked about the links between the concepts in this systematic review.
Name of 2nd reviewer	John Albarran

ADAPTED FROM: NICE.ORG.UK

Appendix 5 – Letter to Head of Nursing

Dear Director of Nursing,

My name is Juliet Girdher and I am currently enrolled on a PhD programme at the University of the West of England, Bristol, being supervised by Associate Professor John Albarran, Dr Rachel Sales and Dr Rebecca Hoskins. The purpose for writing is to seek permission to approach Advanced Nurse Practitioners within your Trust with a view to recruit an appropriate sample of participants. I am planning to gain access to three local NHS Trusts and recruit between 7 and 10 advanced nurse practitioners based in emergency departments and urgent care settings with the aim of exploring the research question below:

What is the lived experience of navigating risk and patient safety for Advanced Nurse Practitioners in clinical practice? A phenomenological study.

The research will involve two in-depth interviews which will be approximately six months apart. The first semi-structured interview will be to identify and describe a specific experience. Between the first and the second interview they will be requested to write two short reflective accounts of experiences, which aim to capture a more in-depth understanding of the topic. It is anticipated that each

interview will last between 30-60 minutes. Data collection will not be held in NHS premises or on NHS time.

The study has been reviewed by the Faculty of Health and Applied Sciences, at UWE, Bristol and it has been given favourable review to proceed. Participation will be voluntary, and responses will be kept anonymous and kept confidential, this will extend to disguising the location of NHS institutions providing access.

If possible, I would be very grateful if you can share the attached 'letter of invitation' with the Nurse Practitioners within your organization or identify the most relevant person within your organization to contact directly who can help me to access potential participants with your permission. If you need more information, then please do not hesitate to contact me. Thank you for your time and consideration.

Kind regards

Juliet Girdher

PhD Research Student, University West of England, Glenside Campus, Bristol.

Clinical Education Lead. Urgent Care Centre, South Bristol Community Hospital

Email: Mobile 07967 439633

Director of Studies: Dr John Albarran, Associate Head of Department for Research and Knowledge Exchange, Faculty of Health and Applied Sciences, Nursing & Midwifery Department, University of the West of England, Glenside Campus, Bristol, BS16 1DD

Tel: +44 (0) 117 328 8611 Email:

Appendix 6 - Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Study Title: *What is the lived experience of navigating risk and patient safety for Advanced Nurse Practitioners in clinical practice? A phenomenological study.*

Invitation: You are being invited to take part in a research study with the aim of researching Nurse Practitioners experience of navigating risk and patient safety in their practice. Before you decide it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully. If there is anything that is not clear or if you would like more information, please get in touch. The study has received a favourable response from the Faculty Research Ethics Committee at the University of the West of England, Bristol.

Purpose of the study: The study will investigate how Nurse Practitioners navigate clinical risk in their practice. This research aims to illuminate and understand an element of practice that has yet to be investigated before and will inform future practice.

Why have I been chosen? You have been chosen to participate because you are an Advanced Nurse Practitioner working in an acute setting with relevant academic

and clinical experience. Your Director of Nursing/Matron has also identified you as suitable and someone who could contribute to informing the aims of this study. It is planned that a minimum of seven participants will be recruited.

Do I have to take part? Participation is entirely voluntary and at your discretion. If you do agree to take part you will be contacted to arrange two dates for undertaking face-to-face interviews. If you decide to take part, you are still free to withdraw without giving a reason. You will need to decide to withdraw within a month of the second interview for a full withdrawal of data collected. A decision not to take part will not have any consequences.

What will happen to me if I take part and what do I have to do? The research will involve two face-to-face semi-structured in-depth interviews where you will be asked to describe an experience about making judgements around managing risk and patient safety in practice. The first interview will be to identify and describe a specific experience and is planned to last between 30 minutes to an hour. The location and time will be mutually agreed. Between the first and the second interview you will be requested to write two short reflective accounts of approximately 500 words on two further experiences in which you have navigated clinical risk and patient safety in practice which will be explored at the second interview. A proforma will be provided for your use. The second interview will take part four to six months after the first at a time and place of your convenience. It is anticipated that this interview will also be around 30-60 minutes and venue and timing will be arranged at your convenience. The expected duration of

participation would be from recruitment to completion of the second interview a maximum of nine months.

What are the possible disadvantages and risks of taking part?

There is a risk that discussing elements of managing risk in your practice may cause you to become upset or distressed. If you think this may be the case then please consider carefully whether to take part in this study. If you find yourself unanticipatedly becoming upset during or after the interview, then please alert the researcher and the interview will be terminated and immediate support offered. In this eventuality please be aware that there are support services available via the University of the West of England and the researcher will support you to access these if necessary and the Director of Studies can offer support to you in this instance. Alternatively contacting the occupational health department at your place of work or your own GP as necessary.

Every effort will be made to limit any inconvenience to you. Rigorous efforts will be made towards representing the information you provide during this study honestly and faithfully. A verbal summary of each interaction will be made to ensure accuracy in interpretation of the content. In addition, information about participant's interactions will be kept anonymous and stored in a password protected computer with access limited to the principal investigator.

What are the possible benefits of taking part? While you may not personally benefit from the study, you will have an opportunity to generate insights about your practice and the value of your role. This process will also be able to be

evidence of the essential reflections that are required for Revalidation. It also potentially offers an opportunity to participate in significant research within your field of practice which will create new knowledge and understandings. There are potential personal benefits of contributing to knowledge regarding the research topic. In addition to this, the opportunity for guided reflection can form evidence for your professional portfolio and the revalidation process.

What if something goes wrong? If something goes wrong or have a complaint then this will be escalated to my Director of Studies Professor John Albarran, who will follow correct procedures as per the policies of the University of the West of England and deal with it accordingly ensuring your best interests.

Will my taking part in this study be kept confidential? Records identifying you as a participant will be kept confidential and any publication of the research will not reveal your identity. All information which is collected about you will have your name and address removed so that you cannot be recognised from it. As the primary researcher I will have sole access to your data prior to it being anonymised. The interviews will be audio-recorded, transcribed verbatim. The recordings will then be destroyed. The transcripts and reflexive accounts will be anonymised at the earliest opportunity and confidentiality maintained at all times.

What will happen to the results of the research study? The transcripts will be analysed for emerging themes and illustrate participants' contributions to the aims of the study. The research process will be reported in part fulfilment of UWE's doctoral descriptors for a PhD. Subsequent to this, it is anticipated that manuscripts

will be developed for publication in relevant high-quality professional nursing journals.

Who is organising and funding the research? I am self-funding this research as a part time Post Graduate student with the academic support and supervision for the University of the West of England.

Contact for Further Information: My contact details as the researcher can be found at the end of this document and please contact me at any time for any further information and advice about this research. You can also contact my Director of Studies: **Dr John W Albarran**, Associate Head of Department for Research and Knowledge Exchange, Faculty of Health and Applied Sciences, Nursing & Midwifery Department, University of the West of England, Glenside Campus, Bristol, BS16 1DD

Tel: +44 (0) 117 328 8611 Email:

Many thanks again for your agreement/interest in participating in this research. I hope your involvement will be a positive and enriching experience for you.

Kind regards

Juliet Girdher

PhD Research Student, University West of England, Glenside Campus, Bristol.

Clinical Education Lead. Urgent Care Centre, South Bristol Community Hospital

RN RSCN MSc AP NMP ENP Mobile number provided in original form).

Appendix 7 – Consent form

CONSENT FORM

For participation in research titled: *What is the lived experience of navigating risk and patient safety for Advanced Nurse Practitioners in clinical practice? A phenomenological study.*

Please tick appropriate boxes	Y	N
Taking part:		
I have read and understood the participant information sheet dates DD/MM/YYYY version two.		
I have been given the opportunity to ask questions about the project.		
I agree to take part in the research which will include being interviewed and audio recorded.		
I understand that my taking part is voluntary, I can withdraw at any time with no reasons.		
Use of the information I provide for this research only		
I understand that personal details such as phone number and address will not be revealed to anyone outside of this research.		
I understand that some of the content discussed may be used in		

publications, reports, web pages and other research outputs but these will be anonymous.

_____

_____

Name of participant (printed) Signature

JULIET GIRDHER

_____

_____

Name of researcher (printed) Signature

Contact details for further information:

Doctoral student: Juliet Girdher RN

Clinical Education Lead.

Urgent Care Centre, South Bristol Community Hospital

Email: Mobile 07967 439633

Director of Studies: Dr John W Albarran,

Associate Head of Department for Research and Knowledge Exchange,

Faculty of Health and Applied Sciences,

Nursing & Midwifery Department,

University of the West of England,

Appendix 8 - Interview Prompt sheet

Interview Guide following Gibbs Reflective Cycle:

Questions at each stage of Gibbs' cycle.

Introduction.

- Thanks for participation.
- Stating the process/expectations rights to terminate at any time.
- Warm up questions: Establishing rapport, relaxing participant.

Description (of experience)

- Can you describe the experience of what happened in the incident which you have chosen to talk about?
- What happened?
- What was it like?

What happened before, during/after…? (establishing facts of the experience)

Feelings

Identify and examine reactions, feelings and thoughts at the time. It is important, although often difficult, to be honest about these.

- Can you identify your feelings at the time…?
- How did you feel when…?
- Can you describe your reaction…?

- Can you explain your feelings?
- What was affecting them?
- Did these feelings change? How do you understand this feeling change?

- How did they affect your actions and thoughts at the time?
- Reflecting back, have your views/feelings on this changed?
- When you examine and reflect on your feelings at the time how do you make sense of them?

Evaluation

Looking back at the judgments you made at the time

- How did you feel things were going at the time?
- What was positive? Negative? What made you think this?
- When you stand back from the experience to gain a sense of how you think it was?
- What made you think something was good or bad?
- Examine your own judgments and what contributed to them. How do you feel about them now?

Analysis

In this section, you need to fully examine and make sense of factors affecting the situation and explore ways to change and develop these.

- Examining this experience in depth…?
- Theorising about key aspects.

- Are there aspects that you identify as an overarching issue?
- Are there key aspects of the experience that affected it profoundly, which needs to be examined for the future?
- Is there anything that you think might have played a central part in the outcome?
- Do you feel anything positively or negatively about this incident, situation in terms of what you did?
- How should it work in this situation?
- Are there theories you aware of or have that make sense of this?
- How do you interpret?
- What helps you make more sense of what happened?
- How does/did this experience fit into your future practice?

Conclusion

- Ask the participant to sum up the key things through the reflective process, the main factors affecting the situation,
- Anything else?
- What has this raised for you?
- How would you conclude…?

Action plan

- What could you do differently next time and how could you prepare for this?

- What areas need developing or planning?
- What resources do you need and where would they be found?
- What steps will be taken first?

Appendix 9 - Interview Transcript Beth's 1st Interview (10 pages)

(Beth is discussing an incident in which she is negotiating for an unwell patient to be transferred to hospital in a car in the context of long ambulance waits).

INT: And that um, that negotiation between you and her um, about whether she was going to go to the nearest hospital, or whether …

BETH: Mm.

INT: … the hospital of her preference. How, how … what did that feel like? What was that like?

BETH: Um, (pause) well that felt fine, um, I think because (pause) I was empowering her to take the choice, with the information that I had at the time. And (long pause) the discussion itself felt quite comfortable. It didn't feel awkward or difficult um; I think that was mainly because of her personality and the fact she was quite open. I can imagine that … and I've had many conversations with people where it hasn't been feeling as comfortable and as okay. Um, and (long pause) she had a lot of insight into … and I, I don't know why she did, but she did have a … seem to have a lot of insight into the problems of ambulances, transport, the fact that this wasn't our nearest A&E department and that um, (long pause) I don't know whether she felt that she was asking something that was unreasonable, going to BRI (hospital name), therefore she was quite open to that negotiation.

INT: Yes, yeah, yeah. And, and then you … when … once you shared that decision and made the decision that she was going to go to the BRI (hospital name), you um, I think what you said, is that you described it, you still felt quite anxious, or worried …

BETH: Yes.

INT: … about that.

BETH:: Yes.

INT: So, what, what, what can you describe that a bit more, that feeling?

BETH: Um, well I suppose you've always got that when people you … comp… compensated for so long and get to the point where everything (makes exploding noise) you know and decompensates. Um, (pause) I did ask them to ring me, when they got there, so um, but that was about my needs not hers really.

INT: Yes, yeah.

BETH: So, um, (pause) I felt quite (pause) I felt I was, I remember thinking at the time this is about my needs not yours, but I need to know you get there safely. Um, (pause) so I was, I was quite reluctant t… t… to, to do that, to put that onus on them, to um, to do that. But I did.

INT: Yes, do we … you mean to ring you …

BETH: Yes.

INT: … when they get there, yeah.

BETH: Was there, yeah, yeah. And see, cos that's about me, not them.

INT: Yes, yeah. And when she went off in the car, what, what…

BETH: I suppose the fact that she was quite sick um, and distressed um, and I, oh I also remember having a conversation about pain relief, because I remember saying, 'if we're gonna put you in an ambulance I can give you morphine, um, if you're going in the car, I can't really do that. So, your … it's going …. it's, it's a toss-up,' I remember this now, 'it's a toss-up between either I give you morphine, we put you in an a, in an ambulance and we get you to wherever, but I can make you less distressed, or you have to embrace the distress,' I didn't quite say it like that, 'and get to where you, you need to be or want to be.'

INT: Yes, yeah, yeah. So, that sounds like a very open conversation that you were having with her.

BETH: Mm.

INT: Ena… enabling you to give that information.

BETH: Mm.

INT: And what do you think enabled you to have that open conversation with her?

BETH: Um, (pause) I'm not entirely sure actually um, (long pause) I tend to have open conversations with patients anyway. I don't beca… I, I, (pause) I try to give them as much information as I'd want to enable them to make decisions that are informed. Um, I, I also will tell them, I think you're making a really big mistake here. So, (pause) I do try and do that. And I don't know whether that comes from this part manager role, where you ans… you have to answer complaints that other ENP has done, where you, you actually think, 'oh why didn't they just say,' …

INT: Yes, yeah.

BETH: Cos that would have made it all alright. Whereas it's coming I think from … I suppose it's, it's experience.

INT: Yes, yeah.

BETH: (pause) And (long pause) and also the experience of being on the other side of the fence, when I've been unwell where (pause) you're treated sort of slightly as other …

INT: Yes.

BETH: … as an object, or objectified as a patient, rather than actually meeting them on a very human face to face level.

INT: Yes, yeah.

BETH: Um, so I think it's, it's a mixture of experience, answering complaints, where you can see … cos you do learn by them when you're answering complaints, you think you know you have a retrospect scope, is a wonderful thing isn't it?

INT: Yes, yeah.

BETH: Um, so it's (pause) and you can see the inexperience in, in some people when they deal with patients, because they don't want to say bad stuff.

INT: Yes, yeah.

BETH: Or, or they, they have a, a need to take control or make things better. That it is impossible to do under those circumstances. (pause) And I suppose it's (pause) about letting them stay in control.

INT: Yes, yeah, yeah.

BETH: Because in some ways, that's um, quite a selfish act, because you're making your own life easier.

INT: Yes. And, and can you explain that a bit more?

BETH: Um, so if you win the patient over and get them on board. (pause) And you … I'm not explaining this very well. (pause) So if you befriend them …

INT: Yes, yeah.

BETH: … you are in a much more powerful position to say things to them …

INT: Yes, yeah.

BETH: … that, that, that might be negative, or, or you can be a lot more honest.

INT: Yes, yeah.

BETH: Um, (pause) as opposed to breezing in and out of a room, and, and not making that connection.

INT: Yes, yeah. So, that, yeah, that's really interesting. So, it's, you feel that it's that connection or that perhaps rapport …

BETH: Mm.

INT: … with, with the patient, that enabled you to have that …

BETH: Yes.

INT: … negotiation.

BETH: And I think that's something that interests me anyway, in (pause) consultation skills is this making and breaking rapport, really quickly. Because you don't have a second chance at it, do you? You, you can't go back and undo something that you've done, that easily, because you're in there for ten minutes or (pause) shorter sometimes. Whereas if you're actually nursing somebody over a period of time (pause) on a ward …

INT: Yes.

BETH: … you can, you have a chance to reprieve yourself …

INT: Yes, yeah, yeah.

BETH: … you can back and undo it … or, but once that (clicks fingers) they're gone and that's the end of that really. So, you haven't got time to rescue the situation, you've got to get it right first time.

INT: Yes, yeah, yeah. And so, time is, or lack of or limited time is, is, is a factor that you're aware of when you are establishing rapport …

BETH: Yes.

INT: … or a connection with a patient.

BETH: Mm.

INT: And would you say that's an important factor in terms of you know, enabling you to manage their risk?

BETH: yes, because if, if you, if you don't get that rapport, quickly, um, and I'm not saying I do it with every patient, every time, and it's also a judgement call about the patients that you need to do that with.

INT: Yes, yeah.

BETH: So, it tends to be (long pause) the vulnerable, the old, the young (pause) and the ones that are just plain downright tricky.

INT: Yes, yeah.

BETH: Um, (pause) we have lots of odd health beliefs in Glastonbury, (place name), as you can imagine.

INT: Yes, yeah.

BETH: So, um, (long pause) sometimes recognising those health beliefs and, and that it sounds awful, it's not actually paying lip service to it, but actually recognising them and thinking this is actually real for them.

INT: Yes, yeah.

BETH: Even if it is bizarre in your eyes. Um, (long pause) allows them to feel a lot more comfortable with you.

INT: Yes, yeah.

BETH: Um, and I think it's something we'd (pause) we do as nurses. (pause) And it's our holistic attitudes, or health … or our beliefs in what we're doing. As in, I was just talking to **** (colleague) earlier, um, about um, some unfortunate experiences that we've all had with general practitioners. Um, and that speed of going in and out and them just cutting you dead, or not treating you as human um, and that's awful. (whispering) please do come back after the.... Um, that it that's something that nurses don't tend to do.

INT: Yes, yeah.

BETH: I mean some nurses do obviously, cos generalisation is a really bad thing, and I'm rambling now. (laughs)

INT: No, no, no I think that, I think the points that you're making are really interesting about how you feel that um, nurses have a sli… or nurse practitioner's um, particularly have um, a sli… a different approach in terms of perhaps being more

holistic and you know, as … when you say GPs might not listen to everything, nurses …

BETH: Mm.

INT: … yo… um …

BETH: And I suppose in some ways the, the consultates… consultation space that we allow, or make, is (pause) even though we have time constraints, it's still tailored to the patients.

INT: Yes.

BETH: Whereas we're not on the ten-minute clock.

INT: Yes, yeah.

BETH: I mean some places, five minutes. Um, so I suppo… we are in a position of being privileged in that …

INT: Yes.

BETH: … it's the … it takes as long as it takes, but we have to move fast.

INT: Yes, yeah, yeah. So, whilst some of it is recognising that you have limited time with that patient to establish a rapport, actually um, within that consultation, you perhaps in some ways, have more time on that specific …

BETH: Mm.

INT: … consultation that you do have, to establish that rapport.

BETH: Mm.

INT: So, that it's sort of, two different ways that times.

BETH: Yes, I su... yes, and I suppose the art is knowing how (pause) how deeply you do that for each patient.

INT: Yes, yeah, yeah. And how do you think you …

BETH: Well then, that comes down to the judgement doesn't it, and sort of being judgemental. So, (laughs) um, if I have … I mean I will do it with ev… or I'll try to do it with everybody, but if I've got (long pause) somebody who's come in with a minor finger injury who's articulate, obviously healthy um, understands what I'm saying to them instantly, I won't be sort of doing that (long pause) not that I even do it consciously, but I'd be moving a lot faster and (pause) being much more closed question.

INT: Yes, yeah, yeah.

BETH: Um, where if I've got somebody who on the other side of the scale, looks really vulnerable or I'm picking up something from them, which makes me think, mm. Er, or if they're very distressed I will be pulling all the stops out to (laughs) …

INT: Yes.

BETH: … to get that rapport.

INT: Yes, yeah. So, you, ah, for in … correct me, I'm just paraphrasing …

BETH: Mm.

INT: … um, but you're descri… describing quite a dynamic um, process perhaps in which, in, in which you are making judgements or decisions about how to guide your consultations …

BETH: Mm.

INT: … according to what your, as you describe, picking up from the patients um, and wha… can you just tell me a bit more about, is it … about you say, what I'm picking up from the patients, what, what is that? What is us picking up from the patients?

BETH: Eerr, it's body language I guess, how hostile they look, how withdrawn they are, where they're (pause) um, (long pause) so I suppose you're picking up all those cues that you get subliminally that you don't even know you're getting.

INT: Yes, yeah.

BETH: So, until you (pause) start analysing it, maybe later, if something has triggered that, you think, yeah that's why I did that, that way, it's because they looked (pause) adrenalized, or distressed, or they might have said a key word that you think, oh, (pause) I wonder why they termed it like that.

INT: Yes, yeah, yeah.

BETH: Yeah.

INT: And, when you say um, picking up cues almost subliminally …

BETH: Mm.

INT: … what is that like? What is going on for you at, at that time?

BETH: Um, (pause) oo, I'm not entirely sure. It's peaking my interest is the best way I can describe it. It's um, (very long pause) I think that's the bit I'm getting more interested in them.

INT: Yes, yeah, yeah. So, when you say you're getting more interested …

BETH: Which makes me sound as though I'm not interested in anybody else.

INT: No. (laughs)

BETH: Which I am (laughs) but I … they're, they're pulling me in.

INT: Yes, yeah.

BETH: I want to unpick them, I want to know what's going on, I want to know how they're feeling …

INT: Yes, yeah.

BETH: … how they're experiencing (pause) whatever experience they're experiencing.

INT: Yes, yeah, yeah. So, it's that, that's … but you've described that really well, in terms of um, something is drawing you in, that means that you're feeling like you want to know more …

BETH: Mm.

INT: … and that's, is that what you mean by pe…

BETH: Yes.

INT: … did you say peaking your …

BETH: Peaking my interest, yeah.

INT: Yeah, yeah. So, it's … peaking sounds like a small thing or a …

BETH: Yeah

INT: … you know, just a … is that how it feels? It just …

BETH: Initially yes, um it's (pause) it's one of those, ooh, moments. Um, (long pause) I, I suppose what's interesting me now is, not the words that are interesting me, but the, the ones that, why are … what I'm doing with the other patients that aren't peaking me in that way.

INT: Yes, yeah.

BETH: This chair squeaks horribly. (laughs)

INT: Oh, do you want, do you want to move? Shall we swap?

BETH: Um, I'll just go and … sorry, do you want to turn your thing off?

INT: No, no, no, that's fine, we can keep it going.

BETH: I'll just put this under there.

INT: You can have that one.

BETH: I'm getting obsessed by the squeak.

INT: No, no, no. You have that one.

BETH: Oo, thank you.

INT: Put that there. There we go.

BETH: I suppose what, what I'm thinking now is, what, what is it about the patients, other patients that reassures me.

INT: Yes, yeah, yeah.

BETH: And I've never thought about that before.

INT: Yes, yeah.

(long pause)

BETH: S… I think its people who are self-assured, confident um, who (very long pause) probably are being reassured with a level of explanation that you're giving um, (long pause) and seem comfortable with it.

INT: Yes, yeah.

BETH: And still seem relaxed and (pause) okay.

INT: Yes, yeah.

BETH: So, that's one end of the sliding scale. And then (pause) the patients that would be peaking my interest, or I would be ha… cranking up the rapport on um, would be the patients who are obviously unwell, distressed, that I know (long pause) are … have a higher degree of acuity or going to need onward transfer or, or are worrying me that they're not going to be compliant or (long pause) or are the risky patients in the middle, which are the ones that I'm going to discharge (pause) opp… and I'm not even thinking of it that consciously, that (pause) I'm not sure what's going on with, so I want to know more.

INT: Yes, yeah, yeah.

BETH: So, I want to know more about not just they're physical symptoms, and the examination and they're vitals. I, I want to know how they're experiencing it.

Appendix 10 – Template for Written Reflection

Reflective Account Template

Reflective Account 1 **ID…….**

Description: Can you describe the incident? What Happened?

Feelings: Can you identify your feelings, reactions during the incident?

Evaluation: Examine your own judgments and what contributed to them

Analysis how do you make sense of factors affecting the situation?

Conclusion: please sum up the key things that have arisen through this reflective process?

Appendix 11 – Reflective Account 2. ID…. Abigail

Description: Can you describe the incident? What Happened?

I was working one day when one of the HCAs asked me to come and see a pts wound, I said can I see another patient first and she said no.
She introduced me to a gentleman who had come for a dressing review at the UCC. He had had surgery at a hospital in a nearby county two weeks ago - a second Hartmann procedure to reverse a colostomy. His wife had refused to redo his dressings as there was ooze underneath and had finally persuaded him to come to hospital. He was not in pain but was visibly anxious.
On examining the wound, he had faecal matter Oozing through the longitudinal stapled scar. The wound was visibly red - there was also visible erythema over the abdo extending 2x 8cm area.
His observations were - 120 temp 38.4 c bp 130/80 rr16 sats 99 on air
Although the bowel sounds his abdo was generally tender and in parts red. My exam was gentle

I talked to the the pt and his wife and was frank - I told them I would like to get an ambulance urgently to the hospital he had surgery so he could see the surgical team to look at his would, I told him it was very likely that he would have surgery that evening.
I asked a colleague to call an emergency ambulance for a septic gentleman with post-surgical complications to the nearby county hospital. I supported her through that as needed to persuade them to go to a hospital slightly further away while I was bleeping surgeons.
I decided to call the surgical registrar on call at that hospital describing a gentleman with an acute abdomen /post-surgical failed anastomosis - requiring emergency surgical assessment. I rang the csm and the ed to expect him so there would not be a delay at their end - that's all I could do.

The ambulance came quickly so we didn't get the fluid up or get a cannula in / he did not have any pain, so we didn't need painkillers.

I talked to the HCA - fed back that it was brilliant call to identify a potentially sick gentleman and get help quickly

Feelings: Can you identify your feelings, reactions during the incident?

Initially - mixture of adrenaline fear and excitement knowing that this gentleman was sick - obvious signs of a failed anastomosis. Old feelings I used to have as an A&E nurse. Excitement that I was back in the groove as I knew exactly what to do when I know someone is sick and fear that I had to get in right and quickly and we were 20 mins away in a community hospital but little to offer than a drip and some oromorph!

Generally - Felt cautious in my approach - keen not to let the above feelings show too much - wanting to be fast, clear but methodical. Aware I didn't want to come across as being caring knowing I had to be very fast or he could deteriorate here in a hospital with no surgeon. Aware that he and his wife were also anxious. Their journey had been complicated - he had had his colostomy reversed and this had been the second-recent procedure and they had recently swapped surgical teams. The HCA was business like as usual - also concerned but proactive - did the observations, carefully removed some of the faecal fluid. She was visibly distressed and although we didn't get to chat at length about what happened - she was glad she was able to convince me see him quickly.

Feeling uncomfortable - On telling relatives the plan re emergency transfer - feel uncomfortable - it always feels so blunt and bold. I hate it. It reminded me of when I had to told a young lad that I was wanted him to see a specialist cos he had diabetes - the impact of those words that condition on someone's life would be enormous. It also reminded me of the time one of the staff asked me to see a receptionist who had been sick with cancer. I took her history and soon as I examined her I knew she was very sick - I remember her asking me am I going to be alright and I said - you need looking after in hospital lovely that all I could say - knowing in the depths of my belly she may die. I looked at this gentleman and with his history and I looked at his wife reaction upset and I knew and she knew this was serious - I knew there was a fair chance he may get sicker on transfer, repeated operations are tricky, repeated operations with sepsis are really difficult.

Small essence of helplessness as I knew if he was sicker at the UCC apart from fluids and pain relief there was nothing I could do but get him to the tight facility.

Found myself thinking about it several times since and talked to the HCA by text too. Feeling worried and upset for the family - especially not knowing what happened.

Evaluation: Examine your own judgments and what contributed to them

I knew he was potentially going to be sick - what contributed to this -

A&E experience - pattern recognition septic news score / anxious pt /concerned as holding his body observations but knew not to flood him with iv fluids (got ready did not start) a volume overload may cause bleeding (we used to do that historically for trauma so pts actually became haemodilute (pre-level one blood warmer)

Bleeding obvious - faecal matter coming through wound!

Surgical knowledge on wards - complications sepsis was Possibility and that it was likely to be localised and had not invaded the full peritoneum at yet but could at any minute. Septic Pt hold their obs and suddenly dive clinically.

Experience with working with junior staff - need to model calmness even in emergency situation to reduce stress for family and increase confidence.

Experience working with Pts and relatives - even though it is uncomfortable - it is better to

be honest with them - be clear.

Personal experience - implications of serious illness and potential sudden death on family. It had been recently been 20 years ago since my mum died suddenly and 18 since my dad died from chronic illness - the emotional impact is devastating. It also directly reminded me of D too so upsetting.

Confidence and support in HCA initially and all UCC team - also recognising every moment needs to be supportive and educational - communication is key. Recognising nurse needed experience calling an emergency ambulance and I knew could support her and bleep the surgical team.

Analysis how do you make sense of factors affecting the situation?

The emotions play important triggers to alert me into action - flight /fight but I have learnt to be professional over the years - learnt this quickly. Aware that I have done emergency and urgent care for 25 years... I enjoy it - some of the old enjoyment came back - it's a strange thing - hoping that we were fast enough to make a difference that day.

I still worry about coming across too blunt with pts and relatives - I am always uncomfortable in these situations. I am northern by birth and heart and I know it wouldn't matter in Yorkshire but ever since moving to the south I have been aware of this.

The decision making around deciding Not to go to local hospital was based on an approx 5-10 min transfer delay to a hospital who had treated him before / would have a copy of his notes... it was a risk as time was essence here.

Knowledge and experience of surgical complications were in the forefront of my mind. Immediate transfer to the correct facility to the correct people was key. My experience as an advanced practitioner when feeling his abdomen - clear he had localised peritonism in abdo and clear that he had a failed anastomosis from faecal leakage that he was unwell / need of surgery

The personal emotions that come up during the experience I can hold in abeyance - I acknowledge them and let them float away if I can and after I cry when I can.
They are normal and natural. I know I cared about the pt too as I am still thinking about how he got on- that never goes away - this is all human nature. I do think you can separate being a nurse from being a person but it's how you deal with it that matters. I haven't cried yet.

Conclusion: please sum up the key things that have arisen through this reflective process?

Clinical practice is an emotional journey
My years of nursing experience and knowledge base has strengthened my practice- advanced practice adds more to my practice - effectively confirming what I know through exam skills with this pt.
My personal experiences in life influences my professional life and of cause vice versa.
I am a reflective practitioner I reflect in and on practice

I apply concepts I have learn and I teach others within my own practice
The story is not always over - I am aware I am not aware of the final outcome with this gentleman. This is an unusual case to see at an UCC - felt like I went back in time for 30mins picking up skills and knowledge from years ago and confirming things with more recent skills from last 14 years ...

Appendix 12 – Analysis Phases – Van Manen Adapted Approach – Summary of Phases of Analysis

First Phase of Analysis *(analysis of data from each participant analysed individually in isolation to stay true to each lifeworld)*

- Each interview/transcript individually analysed
- Field notes, diaries
- Two reflections
- Comparative analysis, combination analysis of all data sources from each participant
- Interpretation of the experience for each participant, with themes

Second Phase of Analysis *(remaining within the lifeworld of each participant in isolation)*

- Preparation for second interviews
- Submerging into *lifeworld* of participants data interview, reflections and field notes
- Identification of key observations, themes or need for enlightenment
- Open-ended questions to test/explore/clarify key observations, structures of experience from previous data to enable shared interpretation/understanding
- Analysis of interviews as per phase one

Third Phase of Analysis *(remaining within the lifeworld of each participant in isolation)*

- Comparative analysis, combination analysis of all data sources from each participant as per steps in phase one
- Interpretation of the experience for each participant, with themes

Fourth Phase of Analysis

- Final holistic comparative analysis for all data
- Merge all findings across all participants, all data for a collective interpretation of the phenomena in question

First Phase of analysis

1A *For each transcript:*

1. Initial reflections immediately posted after each interview
2. Transcription
3. Field notes/diary
4. Listening to interviews as a whole and part by part
5. Line-by-line reading
6. Take a holistic theme from each individual transcript
7. 'Selective', 'highlighting' approach to statements or phrases throughout the transcript
8. These statements/phrases were extracted with an attendant interpretation
9. Thematic analysis - identify themes as 'structures of experience'

and Van Manen's approach to identification of themes:

- group similar or related statements
- Then ask the following four questions:
  - What are the aspects of the uncovered theme?
  - How does the uncovered theme manifest itself?
  - What does the uncovered theme do?
  - How does the uncovered theme do what it does?

1B *For each written reflection*

10. *Repeat steps five through nine*

11. *Merge analysis findings of the two reflections*

12. *Merge analysis findings of the two reflections and first interview for collective analysis*

Appendix 13 – Approval Form

Following confirmation of the necessary changes required, such as consistent terminology, full approval was given in August 2016.

Faculty of Health & Applied Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol BS16 1DD

Tel: 0117 328 1170

UWE REC REF No: HAS.16.07.182

29th July 2016

Juliet Girdher

Dear Juliet

Application title: What is the lived experience of navigating risk and patient safety for Advanced Nurse Practitioners in clinical practice? A phenomenological study

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed with the following conditions:

Ethical issues with the information sheet:

1. On the ethics form it is acknowledged that there is a risk that participants may become upset, but the information sheet does not mention this. The information sheet needs to include an acknowledgement that there are risks involved in taking part. The student could highlight that there is always a chance that discussing their work / patient safety may lead them to become distressed, and that if the participant thinks that this may be the case for them then they should carefully consider whether they wish to take part. It could also be highlighted that if participants do find themselves unanticipatedly becoming upset during or after the interviews then there are support services available (and these should be detailed at the end of the information sheet).

2. The wording of what participation involves could be somewhat clearer in the section on *What will happen to me if I take part and what do I have to do?* Participants need to know what sort of experiences of managing the care of patients they will be being asked about – at the moment it sounds rather general and does not fully inform the participant that this will relate to their judgments around risk and patient safety – although this is mentioned elsewhere, participants may skip straight to this section so it needs to be particularly clear here.

3. There are some minor typing errors on the information sheet that need to be corrected before it is distributed (e.g., you as suitable who – an experiences – - which you will be explored at the second interview, etc. etc.) – this is important so that participants can easily read the information without distraction.

Ethical consideration around withdrawal

4. It could be sensible to introduce a deadline for withdrawal because there are points when it becomes extremely challenging to withdraw data – for example, what would you do if a participant wanted to withdraw when you were half way through analysis, or were about to present your findings, or had published a paper of the results? I would suggest that you state that participants are advised to withdraw within a month of their second interview, and explain on the information sheet that there are points at which they will no longer be able to withdraw (e.g., once the results of your research has been published).

Ethical consideration for care of research participants and the researcher

5. If the participant becomes distressed the student states that i) appropriate support will offered by the researcher and ii) wider support from other services facilitated as necessary. Please ensure that you are clear on what 'appropriate support' you will offer – your role in this project is as a researcher, so I would recommend offering to stop the interview and referring them to other services when you have clarified what these are. Please identify some support services specific to this study / topic area and ensure that these are included on the information sheet for participants (see above).

Design and ethical implications of participant load

6. On the form it is stated 'Once potential participants who meet the essential criteria for recruitment have been identified, meetings will be arranged to outline the broad aims of the study and what will be expected from participants'. It is not clear why you would meet with participants for this purpose – the information sheet should provide this information. To schedule a meeting with every participant may add to participant load and instead, I recommend that the information sheet is sent and participants given the opportunity to ask questions. If a participant seems to need a lot of clarification at that point perhaps meeting in person would be appropriate but I would encourage the student to be flexible about the needs to individual participants.

7. You must not proceed with your research until you have responded to these conditions and have received full unconditional approval from the committee.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx.

Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web: http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx

Appendix 14 – ICH Elements of Valid Informed Consent

The international Conference on Harmonisation (ICH,1996) outlined 20 elements of valid informed consent.

Elements of Informed Consent Required by the ICH Guidelines	
Both the informed consent discussion and the written informed consent form and any other written information to be provided to subjects should include explanations of the following:	
1	That the trial involves research.
2	The purpose of the trial.
3	The trial treatment(s) and the probability for random assignment to each treatment.
4	The trial procedures to be followed, including all invasive procedures.
5	The subject's responsibilities.
6	Those aspects of the trial that are experimental.
7	The reasonably foreseeable risks or inconveniences to the subject and, when applicable, to an embryo, foetus, or nursing infant.
8	The reasonably expected benefits. When there is no intended clinical benefit to the subject, the subject should be made aware of this.
9	The alternative procedure(s) or course(s) of treatment that may be available to the subject, and their important potential benefits and risks.
10	The compensation and/or treatment available to the subject in the event of trial-related injury.
11	The anticipated prorated payment, if any, to the subject for participating in the trial.
12	The anticipated expenses, if any, to the subject for participating in the trial.
13	That the subject's participation in the trial is voluntary and that the subject may refuse to participate or withdraw from the trial, at any time, without penalty or loss of benefits to which the subject is otherwise entitled.
14	That the monitor(s), the auditor(s), the IRB/IEC, and the regulatory authority(ies) will be granted direct access to the subject's original medical records for verification of clinical trial procedures and/or data, without violating the confidentiality of the subject, to the extent permitted by the applicable laws and regulations and that, by signing a written informed consent form, the subject or the subject's legally acceptable representative is authorizing such access.
15	That records identifying the subject will be kept confidential and, to the extent permitted by the applicable laws and/or regulations, will not be made publicly available. If the results of the trial are published, the subject's identity will remain confidential.
16	That the subject or the subject's legally acceptable representative will be informed in a timely manner if information becomes available that may be relevant to the subject's willingness to continue participation in the trial.
17	The person(s) to contact for further information regarding the trial and the rights of trial subjects, and whom to contact in the event of trial-related injury.
18	The foreseeable circumstances and/or reasons under which the subject's participation in the trial may be terminated.
19	The expected duration of the subject's participation in the trial.
20	The approximate number of subjects involved in the trial.

Appendix 15 - Site Demographics

A total of ten participants (five male and five female) were recruited from three settings:

Site A Regional teaching hospital Emergency Department. Practitioners work in both minors and majors with the support of medical staff.	Three participants were recruited from this site (all male).
Site B An Urgent Care Centre (UCC) in a new purpose-built community hospital led by non-medical practitioners	Three participants were recruited from this site (all female).
Site C A group of minor injury units (MIU) based in semi-rural settings with a time distance of at least 40 minutes from the nearest primary hospital. Nurse led units.	Four participants were recruited from this site (two male, two female).

Appendix 16 - Participant Demographics

Pseudonym	Sex	Age dem.	Site	Yrs. ENP	Background
Abigail	f	45-55	B	18	ED background walk in centre experience, UCC last 5 years. Manager role as well as clinical.
Beth	f	45-55	C	15	ED. Then MIU for last 15 years.
Catherine	f	45-55	B	11	ED Bank ENP. Works across several UCC/community settings. Manager role as well as clinical.
Dave	m	35-45	A	17	ED primarily, with two year's UCC experience.
Di	f	45-55	C	17	ED. MIU for the last 15 years.
Kinsale	f	35-45	B	10	Three years walk in centre, 7 years ED two years at current setting UCC
Phil	m	45-55	C	10	ED initially, but last 14 years at MIU. Manager role as well as clinical.
Steve	m	35-45	A	20	Background ED, last 15 years in MIU, Manager role as well as clinical.
William	m	25-35	A	5	ED five years
Ted	m	35-45	C	8	ED seven years. Rural MIU 1 year – current setting

ED – Emergency Department, UCC – Urgent care Centre , MIU - Minor Injury Unit

Key differences:

- Three different sites – urban ED suburban UCC, semi-rural MIU
- gender – five male, five female
- Age demographic - varying 30s, 40s and 50s
- Length of time practising as an ANP
- Background
- Managerial role as well as clinical

Appendix 17 - Beth - Evidence of Theme Development

The key themes identified from Beth's 1st interview

Theme	Subthemes
Establishing rapport	Trust, care, empathy,
Communication	Patient participation, Informed, shared decision making,
Seeking information	Peaking interest, Subjective, objective, rationalizing
Dynamic judgement	Initial impression, Stop pull back,
Safety-netting	Self, patient,
Risk	Inevitability, Tolerance, pushing boundaries
Subjective Feelings	Comfort, concern, peaking interest
Environment	Ability to articulate, junior and senior colleagues, uncertainty, complexity, context
Knowledge	Knowledge base, What is not known, non-linear dimensions
Experience	Pushing boundaries, patterns of experience, holistic view
Reflection/Learning	Understanding, sense making,

Written Reflection Themes:

Themes	Sub themes	1st interview theme link
Supporting junior colleagues	Safe/competent, support learning	Environment
re-evaluate initial impression	Theory testing	Seeking information
Learning from Experience	Experiential knowledge base	
Expanding /changing practice	Reflection post experience	
Initial trigger Feelings	not comfortable Alarm, concern	Feelings
Subsequent feelings:	pleased, glad, comfortable	Feelings
Uncertainty		Environment
Risk taking	Overconfident, risk adverse	

Combined 1st and 2nd Interview and written reflections

Second Interview and Reflection Themes	Links with First Interview Themes	Shared Subthemes
-Internal twang Challenges to rapport Different perspectives (walking a path between)	Establishing rapport	Patient, trust, care, empathy, choice, capacity

- capacity - informed choice - power	Communication	Patient participation informed shared decision making,
- ensuring right information - re-evaluate initial impression 'take a few steps further…'	Seeking information	Peaking interest, Subjective, objective, rationalizing
- no absolute answer - aim between risk taking- risk adverse - Competency - challenge of guidelines - right thing v correct thing	Dynamic judgement	Initial impression stop, pull back,
- safe parameters (caveat to rule breaking)	Safety-netting	Self, patient,
- Levels of risk - Calculated risk - Sharing risk (get out of jail card)	Risk	Inevitability, tolerance, pushing boundaries
- putting feelings in a box - objectifying feelings - heart and head	Subjective feelings	Comfort, concern, peaking interest
Role as a manager – 'collective hive' Teaching risk to others Complex patients Un/supportive environment e.g. business, GP	Environment	Ability to articulate, junior and senior colleagues, uncertainty, complexity, context
Knowledge expansion – facilitating others	Knowledge	Knowledge base, what is not known, non-linear dimensions
Practice development through taking risks	Experience	Pushing boundaries, patterns of experience, holistic view
Resolution v unresolved-	Reflection/Learning	Understanding, sense making,

Appendix 18 - Beth's *Lifeworld* Themes

Theme/Large subtheme	**Subthemes**
Patient *Rapport* *Shared decision making*	Trust, care, empathy, Rapport communication, safe space Subjective feelings comfort, concern, peaking interest Doing the right thing Patient participation, Informed, shared decision making
Context of Work *Uncertainty, complexity*	Uncertainty, complexity, context, ability to articulate, junior and senior colleagues. Collective hub of support
Confronting Risk – **Between the goal posts** *Risk adverse v cavalier*	Inevitability, tolerance, pushing boundaries Safety-netting, self Safety-netting patient,
Uncovering the unknown *Looking/ seeing the whole picture* *Feelings/sensing-*	Seeking information, Initial impression, stop pull back, check list Dynamic judgement, subjective/objective, rationalizing Understanding, sense making, inner self
Knowledge Comfort *Learning, pushing boundaries*	Knowledge base, What is not known, subjective/objective, holistic view Experience, patterns of experience, Reflection/

Appendix 19 - Abigail's *Lifeworld* Themes

Theme /*Large subthemes*	**Subthemes**
Context of time *Uncertainty/Complexity,*	Limited time, complexity uncertainty External objective environment Patient context, practitioner context, colleagues, Crossing boundaries, scope, time Uncertainty litigation
Transparency, Capacity, Choice	Patient communication, capacity, choice, sharing risk, transparency Capacity, informed decision, big googlies
No Stone Unturned Investigating *Emotional Intelligence:*	Seeking objective knowledge, checking process, don't leave a stone unturned, unpicking a story. subjective knowledge, intuition, looking, seeing, visual click, inner subjective voice – awareness of ego, dynamic assessment
Don't miss the risk *Safety caveats*	Managing risk, risk adverse, risky, defensive practice, self-doubt, appraising the evidence, time, Tolerance, acceptance, management, Risk taker and risk adverse. Safety caveats. Sharing risk with others
Expanding knowledge: feel your edges *What is not known* *Learning beyond comfort zone*	What is known, what is not known, Edges of comfort zone, Expanding knowledge, advancing practice Learning, experience.

Appendix 20 - Catherine's *Lifeworld* Themes

Themes/*subthemes*	**Subthemes**
Don't Miss the Risk	Coping, passing on, sharing Risk Tolerance Safety-netting
Knowing the norm *Reflective learning* *Sleepless nights*	Front of mind/ back of mind Norms, Jigsaw Sleepless nights Reflection, learning
Seeking the unknown *Feelings/ Sensing*	Seeking knowledge check list Sensing happiness Happy, not happy Unsettling, worried, concerned Looking, seeing, picture, eyeballing**,** watching
Snapshot – **(Environment)** Uncertainty/ Time	Uncertainty/ Time responsibility, autonomy *Others* colleague's Support
Patient: Happy customer *do the right thing*	Patient: Happy customer, dynamics Manipulative, Power Moral conscience - wanting to do the right thing Safe space – consultation

Appendix 21 - Dave's *Lifeworld* Themes

Theme/*large subthemes*	**Subthemes**
Conveyer belt of time *Environment*	Patient flow, Revolving world, conveyer belt, ducks Other colleagues Uncertainty, slice of luck matrix, Guidelines 'its binary' Role boundaries Expertise, competence, passing buck Safety net
Patient as a commodity *Complexity*	Job to do, role Ducks, Capacity No feeling – no emotional attachment, commodity Patient: Sat on my mind – could have been a friend
Risk on the edge *risk tolerance*	Risk awareness, , risk taker, risk adverse Patient risk, professional risk Control, on the edge, survival, shock, shit hits the wall Coping: sharing, safeguarding Seeking advice, taking the weight off, Passing the buck, Damp squid, need resolution
Snap shot Assessment *Instincts feelings*	Look cues, Subjective/objective assessment quick/slow Feelings happy, worried, concerned, dissatisfied Instincts, resolution, gut
Knowing Normality	Knowledge Base, Norms v stand out. Stop and think Reflection in/on action Opportunity to learn

Appendix 22 - Di's *Lifeworld* Themes

Theme /*Large subthemes*	**Subthemes**
Hoop jumping *Environment*	Uncertainty, complexity Jumping through hoops, holistic Hoop jumping current priorities Litigation, defensive practice
Patient perspective *Informed choice*	Patient: perspective, expectations, informed choice Doing easy thing or right thing
Safe risk taking *Awareness, tolerance*	Awareness, tolerance Risks to learn, Near miss mistakes Safe risks, defensive, Passing On risk – stifle Risk adverse dodge, scared, fear keeps you sharp
Go Back Rethink *Visual clue* *Whole picture* *Feelings*	Initial picture, gut Stop, something not known/understood or missing Rethink seek information objective/subjective Make yourself go back, rethink, Rationalizing niggle, happy, fear keeps you sharp,
To Know or not to know *Reflecting/learning*	Instant, Click, knowledge base, seen before Knowing and awareness Base line, not my bag Feeling: niggle, happy, fear keeps you sharp, Reflecting/learning Satisfaction Resolution

Appendix 23 - Kinsale's *Lifeworld* Themes

Theme/Subthemes	**Subthemes**
Environment factors *Patient: Context*	Uncertainty, busy, time Objectify, justify, litigation Having support, supporting others, power Communication, trust, consent, capacity, choice, onboard
Gut instinct – what did I miss?	Gut feeling Missing somthing
Knowledge Patterns	Back of mind Norms – what to expect, Pattern recognition Patterns of presentation/risk behaviours What's known, not known, Tick lists Sense of knowing, reflection, understanding Learning, Development/change in practice
Risk Coping	Acceptance, tolerance, risk taker, risk adverse Considering potentials Risk coping behaviours, Sharing risk Safety-netting patient, Safety-netting self Rationalize/justify
Seeking information – fit the picture	Confirm diagnosis, initial diagnosis, too quick Fitting the picture Pitfalls, Railroad, side-lined Doubling back, open mind, possibilities Looking/seeing, initial look Numbers/objective subjective Gut-instinct Ticking boxes over gut-instinct

Appendix 24 - Phil's *Lifeworld* Themes

Theme /*Large subthemes*	**Subthemes**
Risk *stratification*	Every day, inevitable, acceptance. Awareness, keeping an eye, visual eye Potential (even if not actual), rule out. Responsibility, coping – sharing with others. Make safe, safety net. Subjective feelings, triggers, drivers and response Fear worried/angry – zing/zip Seeking relief, relieved – squared away
Environment **Patient flow** **Time** *Patient centred*	Time component, complexity, time curve, time dependent i.e. nights. Semantics – minors is no longer minors, safe observable space Other priorities/ perspectives conflict, navigate pathways Supporting others, safety net of support Patient, expectation, empathy, care concern, perspective involvement
Fuelled by emotions	Happy, Fear, worry, anger, uncomfortable Zip, Zing Keeps alert, aware
Knowledge Box *Pushing scope* *Learning*	Forefront of mind, access to knowledge Having fingers burnt, learning from mistakes, hyper-aware, slip back. Less experience, less awareness of risk Comfort zone of knowledge, stuck in a rut, status quo, flat line Reflection, learning, experience
Don't miss the curve ball	Information seeking, dynamic assessment. Initial assessment, immediate assessment, looking/seeing Automatic versus scattergun, curve ball

Appendix 25 - Steve's *Lifeworld* Themes

Theme /*Large subthemes*	**Subthemes**
Risk Balancing Probabilities	Fraught – inevitability, inherent risk, awareness. Tolerance, subconscious internal alarm Confidence, competence, challenge, enjoying risk, cavalier. Fear, paranoia, paralyzed. Threshold of probability, rationalizing. Safety caveats, clinical errors, risk taking, patient safety.
Environment ***Complexity time curve***	Uncertainty, complexity. Time/place perspective Sharing risk, rationalise. Interpretation of guidance, fixed pathways. Litigation, professional risk, luck – touch wood. Patient safety, informed choice, capacity.
Knowledge Learning ***facts as we know them***	Experience and education (hand in hand) Pattern recognition. New knowledge, learning Balance education and experience - supporting others Reflection on drive home third set of traffic lights
Rationalizing	Seeking objective information, history, examination, tests Pigeon hole, don't want to miss something, open mind. Validate hypothesis, avoid wrong path. Subjective/objective, unconscious diagnostic mix, expertise

Appendix 26 - Ted's *Lifeworld* Themes

Theme /*Large subthemes*	**Subthemes**
Sensory/Sensing **Picture building**	Look, visual cues, sensory, sensing, feelings, observation Subjective and objective: patient assessment, history taking. Risk factors, limited information. No assumption. Holistic, instincts, feeling happy/picture of happiness/complete Not happy despite objectively fine, whether the patient is happy.
The What if? Risk	Awareness, perspective, tolerance Risk factors, considering potentials, what could have happened Control, worse-case scenario Probabilities, possibilities, risk taker, risk adverse As safe as it can be, minimize risk Sharing, passing the buck, safety net.
Knowledge roads into back of mind	Current knowledge, back of mind, front of mind. Knowledge base, normality, knowing the norms. New knowledge, mistakes. Reflection learning
Unsafe Environment No safety blanket ***Patient***	Autonomy, accountability, credibility, objectivity valued Uncertainty, role boundaries, ED – safety blanket Uncertainty, complexity, overstretched, busy, short staffed, Capacity to give and receive support Patient capacity, choice, perceived risk, negotiation, risk taking

Appendix 27 - William's *Lifeworld* Themes

Theme /*Large subthemes*	**Subthemes**
Don't miss the golden goose (Risk)	Risk acceptance, risk tolerance, risk management. Risk management, passing it on, sharing, second opinion, Passing the buck, don't miss the golden goose, safety net. Risk taking/adverse owning the risk, pushing boundaries. Guidelines, NOT rules, red flags, safety-netting. Patient sharing strategy, do you want to get imaged? empathy, concern.
Forming a picture *Inner voice subjective feelings*	Something missing, seek and SEE information. Seeking resolution, rationalize, clear or unclear. Rigmarole of patient assessment, check list. Confirmation bias think more broadly. Feelings: Inner voice, happy, not happy, niggle, nagging. intuitive, gut, Comfort, Concern for worst case scenario.
Knowledge boxes *Beneath the wings*	Accessing knowledge, front of mind. Back of mind, comfort zone, pattern knowing. Doesn't fit into box, gaps, going into the unknown. personal knowledge, professional knowledge, other knowledge, experiential knowledge – first experiences, pushing boundaries, beneath the wings, learning
Environment boundaries	Complexity, uncertainty. Support, boundaries, roles, hierarchy objectivity/ subjectivity, Limited resources, different priorities, clipped back, scope Beneath the wings, learning and development

Appendix 28 - Final Collective *Worldhood* Themes

Theme /*Large subthemes*	**Subthemes**
Coping with risk	Potential risk awareness, something missing/ wrong/not known The patient risk or the practitioners' risk, shared with patient Risk assessment, tolerance, management, Worst case versus most probability Safety-netting, safeguarding patient/self as a practitioner. Sharing risk, seeking further information, sharing, second opinion, referring patient.
Sensing/moods: **Fuelled by fear**	Intuiting risk, something missing, filling the gaps. Feelings: worry, care concern, comfort (zone), happy/not happy, emotive driver or barrier, negative/positive. Initial impression, process information quickly. Hypothesis checking, sensing if more information needed. Seeking subjective information, building picture, emotive guiding, internal feeling of what's right for patient.
Seeking information	Subjective, /objective, finding what's missing, not known. rationalising
Comfort zone of knowledge	What is known? What is not known? Pattern recognition, immediate knowing Linking/accessing knowledge, forming understanding, Understanding to interpretation, Experience, reflection, learning. Advancing practice.
Conveyer belt environment	Context, priorities, guidelines. Time pressures, urgent/emergent environment, limited information, uncertainty. Roles, boundaries, support, junior, senior, logistics, dynamics
Patient Sharing	Rapport, trust, communication, informed shared decision Patient participation, sharing risk, choice, risk taking Care/ concern Patient centred care, Practitioner perspective, experience, knowledge, role

Appendix 29 - Final Collective Themes with Heideggerian Interpretation

Themes	Subthemes	Heidegger Interpretation
Coping with risk *Something? Missing Something might happen?* *Management/Coping*	Awareness - Something wrong/different/unknown/missing Whose risk is it? Which perspective? What is the focus? The patient risk or the practitioners' risk Risk: awareness, assessment, tolerance, management Worst case scenario versus most likely calculation Shared with patient, colleagues, others Safeguarding – safety-netting Seeking information link Safety-netting, safeguarding patient, safe guarding self as a practitioner. Safeguarding behaviours – sharing risk, seeking further information, sharing, second opinion, referring, sending to hospital, halting,	**<u>Coping with risk (H)</u>** Already *thrown into the world* of risk Average everyday comes into conscious when hammer is broken Understanding *possibilities* Risk is understood *from the perspective of Dasein* *Authenticity* versus *inauthenticity/Others* Coping with risk *Temporality* – risk is inevitable, and it changes according to *time* and perspective Inevitability of death
Moods: Fuelled by fear Sensing (feelings)	**I**nitial impression, building a picture, Fear - worry, care concern, comfort, negative or positive Driver, barrier care, concern, comfort (comfort zone) Helps process information quickly and form an impression or sensing if there is more information needed, identifying risk.	***<u>Moods (H)</u>*** *Call of care* *Care, concern* *Caring towards* *common sense, Intuition* *Mood* *Anxiety, fear, guilt*
Seeking information ***Revealing/concealing***	Seeking more information. Hypothesis checking.	**<u>Un-concealment (H)</u>** Experience –

	Something missing Objective/ subjective Emotive guiding, filling the gaps Scattergun versus automatic	*understanding – interpretation* Seeking a *clearing*, seeking *Alethea – truth* *Concealment* verses *un-concealment*
Comfort Zone of Knowledge	What is known? What is not known? Linking with knowledge to form understanding. Experience Reflection Learning	***Fore-structure* (H)** Ontology - epistemology Foresight, *fore-structure* *fore-having* *Understanding* *interpretation* *Being towards* *circumspection*
Conveyer belt environment ***Being and time***	Context, roles, boundaries, support, junior, senior, logistics, dynamics Uncertainty, complexity, Priorities, guidelines Practitioner role, status, place Conveyer belt	**Lifeworld (H)** Readiness to hand, presence at hand The they – levelling down - publicness Falling – lack of control *Temporality* – limited time
Patient sharing *Sharing, consent, capacity, perspective*	Patient involvement Rapport, trust, communication, informed shared decision Patient participation, sharing risk, Risk taking Make the patient central – Is the patient central? Commodity, happy customer Caring, concern	***Dasein - Being with*** Dasein, *others* - care *Disclosure*, *discursiveness* Falling – idle talk Mood Dasein interprets itself